Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: eApp (03/09) SERFF Tr Num: MGCC-126107568 State: Arkansas
TOI: H15I Individual Health - SERFF Status: Closed- State Tr Num: 42368

Hospital/Surgical/Medical Expense Disapproved

Sub-TOI: H15I.001 Health - Co Tr Num: CH/MG-25098-EAPP State Status: Disapproved-Closed

Hospital/Surgical/Medical Expense (03/09) AR (FOR CLICO)

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Chalon Ybarra, Courtney Disposition Date: 09/30/2009

Sharp, Jaime Butler

Date Submitted: 05/08/2009 Disposition Status: Disapproved

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: eApplication (CH/MG Combo (03/09))

Status of Filing in Domicile:

Project Number: eApp (03/09)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type:
Submission Type: New Submission Group Market Size:

Overall Rate Impact: Group Market Type:

Filing Status Changed: 09/30/2009 Explanation for Other Group Market Type:

State Status Changed: 09/30/2009

Deemer Date: Created By: Chalon Ybarra

Submitted By: Chalon Ybarra Corresponding Filing Tracking Number:

Filing Description:

Electronic Application Form CH/MG-25098-eAPP (03/09) AR

Company and Contact

Filing Contact Information

Chalon Ybarra, Compliance Analyst II chalon.ybarra@healthmarkets.com

9151 Boulevard 26 817-255-5487 [Phone]

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

North Richland Hills, TX 76180 817-255-8153 [FAX]

Filing Company Information

The Chesapeake Life Insurance Company CoCode: 61832 State of Domicile: Oklahoma

9151 Boulevard 26 Group Code: 264 Company Type: Health

North Richland Hills, TX 76180 Group Name: State ID Number:

(817) 255-3100 ext. [Phone] FEIN Number: 52-0676509

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No

Fee Explanation: \$20.00 per form x 1 form = \$20.00

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

The Chesapeake Life Insurance Company \$20.00 05/08/2009 27744987

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Correspondence Summary

Dispositions

Status Created By Created On Date Submitted

Disapproved Rosalind Minor 09/30/2009 09/30/2009

Objection Letters and Response Letters

Objection Letters Response Letters

Status Created By Created On Date Submitted Responded By Created On Date Submitted

Pending Rosalind Minor 05/15/2009 05/15/2009

Industry Response

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Disposition

Disposition Date: 09/30/2009

Implementation Date: Status: Disapproved

Comment:

Since we have not received a reply to my objection letter of 5/15/09, the filing is being disapproved.

Rate data does NOT apply to filing.

 SERFF Tracking Number:
 MGCC-126107568
 State:
 Arkansas

 Filing Company:
 The Chesapeake Life Insurance Company
 State Tracking Number:
 42368

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Health - Actuarial Justification	Disapproved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Supporting Document	Cover Letter	Disapproved	Yes
Supporting Document	Variability Statement	Disapproved	Yes
Form	Application	Disapproved	Yes

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 05/15/2009 Submitted Date 05/15/2009

Respond By Date Dear Chalon Ybarra,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application, CH/MG-25098-eAPP (03/09) AR (Form)

Comment: The underwriting company should be on the first page of the application and be more prominent than "HealthMarkets".

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Form Schedule

Lead Form Number: CH/MG-25098-eAPP (03/09) AR

Schedule	Form	Form Type Form Name	Action	Action Specific	Readability	Attachment
Item	Number			Data		
Status						
Disapprove	e CH/MG-	Application/Application	Initial		50.000	CHMG-
d	25098-	Enrollment				25098-eApp
09/30/2009	eAPP	Form				_0309_
	(03/09) AR					AR.pdf



PRIMARY APPLICANT: [John Doe]
[PRODUCER NAME: [Bobby Greatagent]]

[Date: [MM/DD/YY]]

APPLICATION SUMMARY

APPLICANT INFORMATION

Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.

[APPLICANT DEMOGRAPHICS]

First Name: [John] Middle Initial: [C]

Last Name: [Doe] Suffix:

Physical (no PO Box) Address: [1234 Anywhere St]

Apt or Suite Number: [Apt. 123]

City: [Ft. Worth]

State: [Texas] **ZIP Code:** [12345-[6789]]

County: [Tarrant] {this will auto-generate based on Physical Address Zip Code and State}

Home Phone Number: [123-456-7890] Cell Phone Number: [456-123-7899]

Daytime Phone Number: [098-765-4321] Fax Phone Number: [987-654-4321]

Preferred Contact

Number: [Daytime]

Best Time to Call: [AM] Email: [john.doe@email.com]

Marital Status: ● Married ○ Single [○ Common Law {this will only be an option IF the state recognizes this as

a legal marriage/unity}] [O Domestic Partnership {this will only be an option IF the state

recognizes this as a legal marriage/unity}]

SSN: [123-45-6789] **Gender**: ● Male ○ Female

Date of Birth: [08/04/1976] Age: [32] {auto-calculation based on "Date of Birth" and today's

date}

Birthplace: [state] Height: [6 feet 2 inches]

Other: [i.e. Russia] Weight: [220]

Occupation/Duties: [none]

Is Applicant a U.S. Citizen? O Yes O No

[Mailing Address]

Mailing Address: [1234 Anywhere St]

Apt or Suite Number: [Apt. 123]

City: [Ft. Worth]

State: [Texas] **ZIP Code**: [12345-[6789]]

[Coverage Information]

Request for Special Effective Date: [01/15/2009]

[Additional Detail

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans)

1. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? ○ Yes ● No



CH/MG-25098-eAPP (03/09) AR

2. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) being tested for or receiving treatment for infertility/fertility, in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage? ○ Yes ● No				
3. Has the Applicant used to	obacco products in th	ne past twel	ve (12) months? ○ Yes • No	
4. Has the Applicant ever ha O Yes ● No	ad or does the Applic	ant current	y have a suspended or revoked Driver's License?	
5. Has the Applicant ever re	ceived any citations	for driving v	while under the influence (e.g. DWI or DUI)? • Yes • No	
6. Has the Applicant ever be	een convicted or pros	secuted for	any criminal activity? ○ Yes • No]	
[Income and Disability Detail				
{The following questions are Only Disability Income Ins Insuranc	e only applicable if Prin surance Certificate) (Fo ce Certificate) (Form # p	orm # [25916 [25915-C]);	ise Applicant(s) chose the "Income Protection Plan" (Accident- G-C]) or the "Income Protection Plus Plan" (Disability Income not applicable for Dependent Applicant(s).} surance (either through your employer or as an individual	
policy)? • Yes • No]	ently have disability	income ins	surance (either through your employer or as an individual	
FAMILY MEMBERS [Family Member 1]				
First Name:	[Jane]		Middle Initial: [A]	
Last Name:	[Doe]		Suffix:	
SSN:	[123-45-6789]	Agor	[20] (auto coloulation based on "Data of Pirth" and today's	
Date of Birth:	[08/19/1978]	Age:	[30] {auto-calculation based on "Date of Birth" and today's date}	
Relationship	[spouse]	Gender:	O Male ● Female	
_	[5 feet 4 inches]	Weight:	[130]	
Birthplace:	[state]	Other:	[i.e. Russia]	
	Occupation/Duties:	[working v	voman]	
	licant a U.S. Citizen?		O No	
Same address as Prin	nary Applicant? ● \	res O No		
			ntal Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or 23-IP (5/07) AR) only (they are applicable for all other plans}	
1. Has the Applicant used to	obacco products in th	ne past twel	ve (12) months? ○ Yes • No	
2. Has the Applicant ever ha ○ Yes • No	ad or does the Applic	ant current	y have a suspended or revoked Driver's License?	
3. Has the Applicant ever re O Yes ● No	ceived any citations	for driving v	while under the influence (e.g. DWI or DUI)?	
		ecuted for	any criminal activity? ○ Yes • No]	
[Income and Disability Detail				
Only Disability Income Ins	surance Certificate) (Fo	orm # [25916	se Applicant(s) chose the "Income Protection Plan" (Accident-6-C]) or the "Income Protection Plus Plan" (Disability Income not applicable for Dependent Applicant(s).}	

1. Does the Applicant currently have Disability Income Insurance (either through your employer or as an individual

2



policy)? ○ Yes • No]				
[F1M				
[Family Member 2]	ID-1-1		841 1 11 - 1-14	'-I ID1
First Name:	[Baby]		Middle Init	• •
Last Name:	[Doe]		Suf	TIX:
SSN:	[123-45-6789]	A	[0] (- (Care based as IID to at D'All and to do la
Date of Birth:	[01/17/2006]	Age:		tion based on "Date of Birth" and today's
Dolotionobin	[danandant]	0	date}	
Relationship	[dependent]	Gender:	• Male • Fem	iale
Height:	[3 feet 1 inches]	Weight:	[42]	
Birthplace:	[TX]	Other:	[i.e. Russia]	
la A	Occupation/Duties:		O No	
	licant a U.S. Citizen?		O No	
Same address as Prir				O Vee A Ne
la Dan			on/guardianship?	
is Depo	endent Applicant bet			
			ull-time student?	• Yes O No
		[[If "Yes",]	Name of School:	[Great University]]
		_	Explain:	[details]
Is this Applicant incar				
mental retardation o				O.V. a. Na
	Primary Applicant fo	or support ar	nd maintenance?	O Yes ● No
FA JURE I Barail				
[Additional Detail	NOT amplicable for the		. (. D / D (.)	
				surance Policy, form 26099-IP (1/08)) and/or
the "MEGA Vision Plan" (vision insurance Polic	cy, form 2602	23-IP (5/07) AR) on	ly (they are applicable for all other plans}
1. Has the Applicant used to	obacco products in t	he past twel	ve (12) months?	O Yes ● No
2. Has the Applicant ever ha ○ Yes • No	ad or does the Applic	cant current	ly have a suspend	ed or revoked Driver's License?
3. Has the Applicant ever re	ceived any citations	for driving	while under the in	fluence (e.g. DWI or DUI)? • Yes • No
4. Has the Applicant ever be	een convicted or pro	secuted for	any criminal activ	ity? ○ Yes ● No]

CHOICE OF COVERAGE

The following [Certificates] [Policies] are underwritten by The Chesapeake Life Insurance Company:

[Plan Name]	[Applicant(s)]	[Description]	[Monthly Premium]
[Chesapeake ESSENTIAL Fit (Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (EFIL)]	[John Doe]	[Calendar Year Deductible: [\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network \$5,000 per Family, In-Network / \$10,000 per Family, Out-of-Network]] Coinsurance:	[\$\$\$.\$\$] [Incl.]
		[70% In-Network / 50% Out-of-Network]	
		Calendar Year / Lifetime Maximum: [\$1,000,000 / \$2,000,000] [Coinsurance Maximum (per Calendar Year): [\$2,500 per Person, In-Network / \$5,000 per	



		Dansas Out of Naturals	
		Person, Out-of-Network \$5,000 per Family, In-Network / \$10,000 per	
		Family, Out-of-Network]	
		Option of Network:	
		[023-Private Health Care Systems (PHCS)]	
[Chesapeake BASIC Fit (Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26220 PPO-IP (03/09) AR] (BFIL)]	[Jane Doe] [Baby Doe]	[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible: [\$2,000 per Person, In-Network / \$4,000 per Person, Out-of-Network]]	[\$\$\$\$.\$\$] [Incl.]
(5) 12)		Coinsurance: [70% In-Network / 50% Out-of-Network]	
		Lifetime Maximum: [\$500,000]	
		Hospital Inpatient & Miscellaneous / Inpatient Surgeon Maximum Benefit Amount: [\$7,500 / \$3,000]	
		Outpatient Surgery Facility / Outpatient Surgeon Maximum Benefit Amount: [\$3,750 / \$1,000]	
		Option of Network: [023-Private Health Care Systems (PHCS)]	
[Physician Office Services Benefit Rider (Form # CH-26223-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	Copayment (per Person, per Visit): [\$25 In-Network / \$50 Out-of-Network]	[\$\$\$\$.\$\$] [Incl.]
		Visit Limitation (per Person, per Calendar Year): [2]	
[Outpatient Accident Expense Benefit Rider (Form # CH-26221-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	Copayment (In-Network and Out-of-Network): [\$50]	[\$\$\$\$.\$\$] [Incl.]
		Maximum Benefit Amount (per Person, per Calendar Year): [\$500]	
[Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form # CH-26224-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	[Copayment][Facility Fee] (per Person, per Visit): [\$150 In-Network / \$300 Out-of-Network]	[\$\$\$\$.\$\$] [Incl.]
(((() .)		[Combined Visit Limitation (per Person, per Calendar Year): [15]]	



[John Doe] [Jane Doe] [Baby Doe]		[\$\$\$.\$\$] [Incl.]
[John Doe] [Jane Doe] [Baby Doe]	[[Copayment][Facility Fee] (per Person, per Visit): [\$250 In-Network / \$500 Out-of-Network]]	[\$\$\$.\$\$] [Incl.]
	[Maximum Benefit Amount (per Person, per Day): [\$500]]	
	[Maximum Benefit Amount (per Person, per Calendar Year): [\$2,500]]	
[John Doe] [Jane Doe] [Baby Doe]		[\$\$\$.\$\$] [Incl.]
[John Doe] [Jane Doe] [Baby Doe]	Guarantee Level: [24] months	[\$\$\$.\$\$] [Incl.]
[John Doe] [Jane Doe] [Baby Doe]	Maximum Benefit Amount (per pregnancy/childbirth): [\$1,000]	[\$\$\$.\$\$] [Incl.]
[John Doe]	Maximum Benefit (per person, Calendar Year): [\$1,500]	[\$\$\$\$.\$\$] [Incl.]
	Generic / Brand Drug Deductible (per Person, per Calendar Year): [[\$0 / \$250]]	
	Retail: Generic Preferred Drugs, [30] day supply: [100%] less [\$5] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$15] copayment Brand Preferred Drugs, [30] day supply discount: [50%] Brand Non-Preferred Drugs, [30] day supply discount: [25%]	
	Mail-Order: Generic Preferred Drugs, [90] day supply: [100%] less [\$15] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [\$45] copayment Brand Preferred Drugs, [90] day supply discount: [50%]	
	[Jane Doe] [Baby Doe] [John Doe] [Jane Doe] [Jane Doe] [Jane Doe] [Jane Doe] [John Doe] [Jane Doe] [Jane Doe] [Jane Doe] [Baby Doe]	[Jane Doe] [Baby Doe] [John Doe] [Jane Doe] [Baby Doe] [Septiment of the process of the proces



		Brand Non-Preferred Drugs, [90] day supply discount: [25%]	
[Prescription Drug Expense Rider (Form # [(CH-26222-IR (03/09) AR)]]	[Jane Doe] [Baby Doe]	Maximum Benefit (per Person, per Calendar Year): [\$500]	[\$\$\$.\$\$] [Incl.]
		Deductible (per Person, per Calendar Year): [\$250]	
		Retail: Generic Preferred Drugs, [30] day supply: [100%] less [\$5] [\$10] [\$15] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$20] [\$25] [\$30] copayment Brand Name Drugs, [30] day supply discount: [25%]	
		Mail-Order: Generic Preferred Drugs, [90] day supply: [100%] less [\$10] [\$20] [\$30] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [\$40] [\$50] [\$60] copayment Brand Name Drugs, [90] day supply discount: [25%]	

		NON-NETWORK: Deductible: [\$0] Comprehensive Eye Exam: [\$30] Corrective Spectacle Lenses: [75%]	
		Comprehensive Eye Exam: [\$30] Corrective Spectacle Lenses: [75%]	
		Comprehensive Eye Exam: [\$30] Corrective Spectacle Lenses: [75%]	
		Deductible: [\$0]	
		Follow-Up Visits: [Not Covered]	
		Frames: [Not Covered] Contact Lens Fitting: [Not Covered]	
		Corrective Contact Lenses (Therapeutic): [100%]	
		Disposable): [\$40]	
		Corrective Spectacle Lenses: [100%] Corrective Contact Lenses (Non-Disposable or	
[(26023-IP (5/07) AR)]) (VSIN)]	[Baby Doe]	Comprehensive Eye Exam: [100%]	
Insurance Policy) (Form #	[Jane Doe]	Deductible: [\$0]	[Incl.]
[MEGA Vision Plan (Vision	[John Doe]	NETWORK:	[\$\$\$\$.\$\$]

Policy) Form # [26099-IP (1/08)]

Deductible: [\$0]]

[Incl.]

[Date: [MM/DD/YY]]

[Jane Doe]



(DTLB)]	[Baby Doe]		
[MEGA CancerWise (Cancer Benefit Policy) (Form # [(26055-IP (5/07) AR)]) (ECAN)]	[John Doe] [Jane Doe] [Baby Doe]	First Diagnosis Cancer Benefit Amount (per person, per lifetime): [\$10,000]	[\$\$\$\$.\$\$] [Incl.]
[Income Protection (Accident- Only Disability Income Insurance Certificate) (Form # [25916-C]) (DIGP)]	[John Doe]	Monthly Indemnity Benefit (per disabled person): [\$500] Elimination Period (per disabled person): [30] days	[\$\$\$\$.\$\$] [Incl.]
[Income Protection Plus (Disability Income Insurance Certificate) (Form # [25915-C]) (DSGP)]	[Jane Doe]	Monthly Indemnity Benefit (per disabled person): [\$500] [White Collar: Yes]	[\$\$\$\$.\$\$] [Incl.]
[Waiver of Premium Benefit Rider (Form # [25917])]	[John Doe] [Jane Doe]		[\$\$\$\$.\$\$] [Incl.]
[Endorsement Return of Premium Benefit (Form # [25918])]	[John Doe] [Jane Doe]		[\$\$\$\$.\$\$] [Incl.]
[Critical Care Plus (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C]) (Cl01)]	[John Doe] [Jane Doe] [Baby Doe]	First Occurrence Benefit Amount (per person, per lifetime): [\$10,000]	[\$\$\$\$.\$\$] [Incl.]
[MEGA Accident Advantage (Accidental Injury Only Insurance Certificate) (Form # [26038-C]) (ASLG)]	[John Doe]	Accidental Injury Benefit Amount, per person, per year: [\$5,000]	[\$\$\$.\$\$] [Incl.]
[Accident Expense Insurance Plan (Accident Catastrophic Expense Plan Certificate of Insurance) (Form # [25314]) (IA08)]	[Jane Doe] [Baby Doe]	Deductible, per person, per occurrence: [\$2,400] Maximum Benefit, per person, per occurrence: [\$6,000]	[\$\$\$\$.\$\$] [Incl.]
		Coinsurance: [50%]	
[Accident Expense Benefit Rider (Form # [25096])]	[John Doe] [Jane Doe] [Baby Doe]	Deductible, per injury: [\$0] Maximum Benefit, per injury	[\$\$\$\$.\$\$] [Incl.]
[Direct Benefit (Hospital Confinement Indemnity	[John Doe] [Jane Doe]	[\$600] Daily Benefit Amount (per person): [\$100]	[\$\$\$\$.\$\$] [Incl.]
Certificate) (Form # [25874-C]) (DB01)]	[Baby Doe]		



[023-Private Health Care Systems		[\$\$\$\$.\$\$]
(PHCS)]		[Incl.]
[Certificate][Policy] Fee		[\$\$\$.\$\$]
		[Incl.]
	Total Estimated Recurring Payment:	[\$\$\$\$.00]
	Total Initial Payment:	[\$\$\$\$.00]

The estimated premium is provided prior to review by the Underwriting Department and may change after underwriting review. You will be notified if there is any change to the estimated recurring payment as a result of underwriting review.

{The following section is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans)

PHYSICIAN DETAILS (Name of current Physician and any other Physician or specialist seen in the past 12 months)
APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Primary Applicant: [John Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code**: [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]

Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Spouse Applicant: [Jane Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]
City: [My Town]

State: [My State] **ZIP Code**: [09876-5432]

[Date: [MM/DD/YY]]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care

VY Physician/Specialist/Orgent Care
Center/Hospital? [MM/

nter/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]

Recommendation(s)? [recommendations]



APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Dependent Applicant: [Baby Doe]

Physician/Specialist Name: [Baby Doctor, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC] City: [My Town]

[My State] State: **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care

> Center/Hospital? [MM/YYYY] Reason(s)? [reason] Result(s)? [results]

Recommendation(s)? [recommendations]

{The following section is only applicable if "10 Year Term Life Plan" (Renewable Term Life Insurance Plan Certificate, form 25919-IP (1/09) TX is chosen. This section will replicate for every Applicant that applied for the Renewable Term Life Insurance Plan Certificate.}

BENEFICIARY INFORMATION

John Doel Beneficiary Information Details

BENEFICIARY 1

First Name: [Jane]

Last Name: [Doe]

Beneficiary Relationship:

[Wife]

Other:

[Fabulous] City: State: [State]

[12345-9876] Zip:

BENEFICIARY 2

First Name: [Baby]

Last Name: [Doe]

Beneficiary Relationship:

[Son]

Middle Initial: [B]

Suffix: Percentage: [XXX%]

Middle Initial: [A]

Suffix:

Percentage: [XXX%]

Other:

Citv: [Fabulous] State: [State]

Zip: [12345-9876]

PRIOR COVERAGE

(The following question is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans)

MEDICARE/MEDICAID

Is any Applicant eligible for or currently covered under Medicare or Medicaid? • Yes

[If "Yes", who? Reason

> O [John Doe] [Financial] [Medical] O [Jane Doe] [Financial] [Medical] O [Baby Doe] [Financial] [Medical]

CURRENT HEALTH INSURANCE

During the past two years, has any person to be insured had insurance declined, postponed, had a waiver applied, or charged additional premium for life, disability or health insurance or had such insurance rescinded? ○ Yes ● No



Does any Applicant currently have health insurance or has any Applicant had health insurance within the past 12 months? ○ Yes ● No [If "Yes", has coverage been in force within the past 60 days? ○ Yes ○ No] [If "No", date of cancellation: [MM/YYYY]]
CURRENT LIFE INSURANCE Does any Applicant currently have life insurance or annuities? ○ Yes ● No
Will the insurance applied for replace or otherwise reduce in value any life insurance or annuities now in force? ○ Yes ● No

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans)

[MEDICAL QUESTIONS

Have you or any Applicant EVER had symptoms, been diagnosed, receiv	ved medical advice or been treated for:
1. Hazardous Activities or Sports - does Any Applicant to be insured engage in any hazardous sport or activity? [If "Yes", is it professionally or for recreation?	Yes ● NoProfessionally ○ Recreationally]
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
2. Heart or Cardiovascular Conditions/Disorders including but not limited to - Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
3. Endocrine Disorders including but not limited to – Diabetes (high blood sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
4. Blood Disorders including but not limited to - Blood or spleen disorder, including anemia, leukemia, high cholesterol, or hyperlipidemia?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
5. Gynecological Disorders including but not limited to – male or female reproductive organ disorder or disease, including breast disorder or augmentation?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe] ○ [Baby Doe]
6. Cancer / Tumor or any benign or malignant growths, including but not limited to - Cancer, cyst, tumor, or neoplasm?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]



	○ [Baby Doe]
7. Respiratory Disorders including but not limited to - Respiratory disorder, including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea, or breathing problems?	O Yes ● O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
8. Urinary Tract Disorders including but not limited to - Kidney, bladder, urinary tract, stones, or prostate disorders?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
9. Digestive Tract Disorders including but not limited to – GERD (gastroesophageal reflux disease), Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis,	
hepatitis, or pancreatitis?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
10. Colon Disorders including but not limited to - Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
11. Eye, ear, nose, or throat disorders - Eye, ear, nose, or throat disorders?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
12. Skin Disorders including but not limited to - Skin disorders, burns, lacerations, dermatitis, boils, chronic rashes, or melanoma?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
13. Musculoskeletal Disorders including but not limited to - Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
14. Complications of Pregnancy including but not limited to - Cesarean section?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
15. Brain Disorders including but not limited to - Epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
16. Mental and Nervous Disorders including but not limited to - Depression, anxiety, alcoholism, alcohol abuse, drug abuse, or drug addiction?	O Yes ● No
Select all Applicants this question applies to:	○ [John Doel ○ [Jane Doel



17. Connective Tissue Disorders including but not limited to - Hodgkin's or Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue	O [Baby Doe]
disease?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
18. Abnormal Test Results - Any abnormal results of a cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
19. Symptoms of other Medical Conditions - Abnormal bleeding, swollen or enlarged prostate, or night sweats?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
20. Muscular Disorders - Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of	
use of any limbs?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
21. AIDS / HIV - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an	- [====, ===]
AIDS-related test?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22a. Recent Medical Treatment - WITHIN THE LAST 5 YEARS, have you had any other medical or surgical advice, hospitalizations, treatment, operations, or	
testing?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22b. Recent Medical Treatment – WITHIN THE LAST 3 YEARS, have you or any Applicant taken, been advised to take, or been prescribed any medication(s), including any which were not filled?	O Yes ● No
[If "Yes", what condition(s) is the prescribed medication for?]	[conditions]
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22c. Recent Medical Treatment – Have you or any Applicant(s) been advised to have additional testing, lab work, surgical or medical treatment, or had such that has not yet been completed?	O Yes ● No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doel]



23. Family History - Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or diabetes? Select all Applicants this question applies to: Select all Applicants this question applies to: [Baby Doe] 24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? Select all Applicants this question applies to: Select all Applicants this question applies to: [John Doe] ○ [Jane Doe] ○ [Baby Doe] 25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke, disease of the heart or blood vessels, renal failure, multiple sclerosis, carcinoma in situ,	The following questions are only applicable if Applicant(s) chose the "Critical Care/Plus Pla. Major Organ Transplant Certificate) (Form # [25936-C])}	n" (Specified Disease/Condition Or
Select all Applicants this question applies to: Select all Applicants this question applies to: Select all Applicants this question applies to: [Baby Doe] 24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? Select all Applicants this question applies to: Select all Applicants this question applies to: [John Doe] ○ [Jane Doe] [Baby Doe] 25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke,	been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer	
24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? Select all Applicants this question applies to: Select all Applicants this question applies to: [Baby Doe] Yes ● No [Baby Doe] Joel [Baby Doe] Select all Applicants this question applies to: [Baby Doe] [Baby Doe] [Baby Doe] [Baby Doe]		O Yes ● No
transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? Select all Applicants this question applies to: Select all Applicants this question applies to: [John Doe] ○ [Jane Doe] ○ [Baby Doe] 25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke,	Select all Applicants this question applies to:	
Select all Applicants this question applies to: O [John Doe] O [Jane Doe] D [Baby Doe] 25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke,	. , , , , , , , , , , , , , , , , , , ,	
25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke,	heart/lung combined or bone marrow?	O Yes ● No
physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke,	Select all Applicants this question applies to:	
	physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke,	
coronary artery by-pass surgery, coronary angioplasty or Alzheimer disease? ○ Yes • No	coronary artery by-pass surgery, coronary angioplasty or Alzheimer disease?	O Yes ● No
Select all Applicants this question applies to: O [John Doe] O [Jane Doe] O [Baby Doe]	Select all Applicants this question applies to:	

PAYMENT INFORMATION

[CREDIT/DEBIT CARD INITIAL PAYMENT] 1st Payment: [\$\$\$.00] [O VISA O MasterCard] **Credit Card Type:** Name of Cardholder as it appears on the card: [John Doe] **Relationship of Payor to Primary Applicant:** [self] [Reason for Payor Being Different than Applicant: [reason]] Type of Card: [O Credit O Debit] **Account Type:** [Personal] **Credit Card Number:** [5525-XXXX-XXXX-XX54] **Expiration Date:** [01/10] Cardholder's Billing Address Line 1: [address] Cardholder's Billing Address Line 2: City: [city] State: [TX]

Zip:

Cardholder's Phone Number:

[ONGOING PAYMENTS]

Ongoing Payments: [● Checking Account Electronic Fund Transfer (EFT)

O Savings Account Electronic Fund Transfer (EFT)

O Bill Me]

[zip code]

[phone number]

Payment Mode: [● Monthly ○ Quarterly ○ Annually]

Bank Routing Number: [xxxxx9485]
Bank Account Number: [xxxxx0089]
Confirm Bank Routing Number: [xxxxx9485]
Confirm Bank Account Number: [xxxxx0089]

Account Type: [Personal]

Name of Financial Institution: [My Favorite Bank]



Primary Name on Bank Account: [John C Doe]
Relationship of Payor to Primary Applicant: [relationship]
[Reason for Payor Being Different than Applicant: [reason]]

HEALTH APPLICATION TERMS AND CONDITIONS

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the certificate/policy is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

ELECTRONIC SIGNATURE – [John Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

ELECTRONIC SIGNATURE - [Jane Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

FOR HOME OFFICE USE ONLY

Special Request(s): [office use only text] {only agent allowed to fill in text here}

[Association] Membership: [NASE Premiere] {system-generated} [Association] Membership Number: [0123456789] {system-generated} [09/15/2008] {system-generated} [06/15/2008] {system-generated}

Lead ID: [1234-ABC]

Market Type: [Association Group (I)]



ELECTRONIC SIGNATURE – [Bo	obby Greatagentj		
Producer ID: [123456789]			
		osed Insured(s) is intending to replace	ce or otherwise reduce in value
any existing life insurance or ann	uities? O Yes O No		
By checking the box and entering electronically sign this application	•	cating my agreement with the indicat	ted statement and my intent to
, , , , , , ,			
☐ I certify that each question answers given by the Appli		ked by me of the Applicant(s), and	I have accurately recorded all
OR			
☐ I certify to the best of my k on this application.	nowledge and belief the Appl	cant(s) has/have personally recorded	d the answers to each question
Please type your name in the spa First Name: [Bobby]	aces below to electronically si MI: [B]	gn your application. Last Name: [Greatagent]	Suffix:
Please re-type your name in the s First Name: [Bobby]	spaces below to confirm your MI: [B]	signature. Last Name: [Greatagent]	Suffix:

END OF APPLICATION FOR INSURANCE

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)

Supporting Document Schedules

Item Status: Status

Date:

Satisfied - Item: Flesch Certification Disapproved 09/30/2009

Comments:

Attachments:

AR.CLICO CH.MG-25098-eAPP _0309__Cert Compl Rule-Reg19.pdf

AR.CLICO CH.MG-25098-eAPP _0309__flesch.pdf

Item Status: Status

Date:

Satisfied - Item: Application Disapproved 09/30/2009

Comments:

This submission is for a new application.

Item Status: Status

Date:

Bypassed - Item: Health - Actuarial Justification Disapproved 09/30/2009

Bypass Reason: N/A - Application only filing

Comments:

Item Status: Status

Date:

Bypassed - Item: Outline of Coverage Disapproved 09/30/2009

Bypass Reason: N/A - Application only filing

Comments:

Item Status: Status

Date:

Satisfied - Item: Cover Letter Disapproved 09/30/2009

Comments:

Attachment:

Company Tracking Number: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)

TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical

Hospital/Surgical/Medical Expense Expense

Product Name: eApp (03/09)

Project Name/Number: eApplication (CH/MG Combo (03/09))/eApp (03/09)
AR.CLICO CH.MG-25098-eAPP _0309__Cover Letter.pdf

Item Status: Status

Date:

Satisfied - Item: Variability Statement Disapproved 09/30/2009

Comments:

The attachment exceeded the maximum size limit allowed by SERFF; therefore, it was split into two separate files.

Attachments:

VAR STMT CHMG-25098-eApp _0309_ AR - File 1 of 2.pdf

VAR STMT CHMG-25098-eApp _0309_ AR - File 2 of 2.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: The Chesapeake Life Insurance Company

Form Number(s):
CH/MG-25098-eAPP (03/09) AR
I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements
of Rule and Regulation 19.
Susan E. Dew
Signature of Company Officer
Susan Dew
Name
Senior Vice President, Associate General Counsel and Chief Compliance Officer
Title
May 8, 2009
Date

Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name: Application

Form Number: CH/MG-25098-eAPP (03/09) AR

Flesch Reading Ease Score: 50

Susan E. Dew

Susan Dew

Senior Vice President, Associate General Counsel and Chief Compliance Officer The Chesapeake Life Insurance Company

May 8, 2009

Date



P 817-255-5487 **F** 817-255-8153 www.HealthMarkets.com 9151 Boulevard 26 North Richland Hills Texas, 76180

May 8, 2009

Commissioner Jay Bradford Arkansas Insurance Department Life and Health Division 1200 West Third Street Little Rock, AR 72201

RE: The Chesapeake Life Insurance Company

NAIC No. 264-61832 FEIN No. 52-0676509

SERFF Tracking # MGCC-126107568

Form Number: Description:

CH/MG-25098-eAPP (03/09) AR Application for Insurance

<u>Supporting Documentation (FOR INFORMATIONAL PURPOSES)</u> (VAR STMT) CH/MG-25098-eAPP (03/09) AR Statement of Variability

Dear Commissioner Bradford:

The above referenced form, **CH/MG-25098-eAPP (03/09) AR**, is submitted for your review and approval. This form is new and not intended to replace any forms currently approved by your Department.

Upon approval, the enclosed Application form CH/MG-25098-eAPP (03/09) AR is intended to be used to solicit coverage by electronic means with our previously approved group/individual ancillary plans underwritten by our sister company, The MEGA Life and Health Insurance Company, as well as the following individual health plans underwritten by The Chesapeake Life Insurance Company, forthcoming under separate cover:

COMPANY FORM NUMBER	DESCRIPTION
CH-26210 PPO-IP (03/09) AR	Catastrophic Expense Preferred
	Provider Organization (PPO) Policy
CH-26220 PPO-IP (03/09) AR	Limited Benefit Basic Medical-
	Surgical Expense Preferred Provider
	Organization (PPO) Policy

This application is concurrently being filed for review and approval under our sister company, The MEGA Life and Health Insurance Company. It is our hope that this application may also be used to solicit coverage by electronic means for various group/individual health and ancillary plans that may be submitted to the Department for review and approval in the future.

Additionally, enclosed is a very detailed **Statement of Variability** version of this Application form, form number **(VAR STMT) CH/MG-25098-eApp (03/09) AR.** This version contains extensive information reflecting every possible question and product scenario that could be presented through the electronic application process. This form is intended to be viewed as supporting documentation, for informational purposes. We understand that this is a lot of information, so please do not hesitate to contact me, Chalon Ybarra, directly (collect, if preferred) at (817) 255-5487, or via email at chalon.ybarra@healthmarkets.com. I am eager to discuss any questions you may have regarding the information enclosed herewith.



Upon approval, this form will be used electronically via an internet-based system currently under development by outside contractor Connecture, Inc. To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

Your assistance in this matter is greatly appreciated.

Sincerely,

Chalon Ybarra

Product Compliance Analyst II Compliance Department

Chalon ybana

HealthMarkets®

9151 Boulevard 26 • North Richland Hills • TX 76180 **P** (817) 255-5487 • **F** (817) 255-8153 chalon.ybarra@HealthMarkets.com • www.HealthMarkets.com



PRIMARY APPLICANT: [John Doe] [PRODUCER NAME: [Bobby Greatagent]]

			[· · · · · · · · · · · · · · · · · · ·	
APPLICATION SUMMARY				
APPLICANT INFORMATION				
lote: All of the information you p	provide is for quoting and	application purposes only a	and will be kept confident	ial.
Is the Primary Applicant	an adult danandant?	O Yes O No		
{If "Yes":}	an addit dependent?	O Tes O No		
Home Phone Numbe		Cell Phone Number:	[456-123-7899]	
Daytime Phone Numbe	r: [098-765-4321]	Fax Phone Number:	[987-654-4321]	
Is this a child-only applic {// "Yes":}	ation?	O Yes O No		
applying for child-only cover ny, on the Family Members pa APPLICANT DEMOGRAPHICS	age.	dest child as the Primary	Applicant and all addit	ional children, if
First Nam		Middle Initi	al: [C]	
Last Nam	ne: [Doe]	Suff		
Physical (no PO Box) Addres				
Apt or Suite Numb				
	ty: [Ft. Worth]	71D 0 -	Jan [400.45 [0700]]	
Sta Coun	te: [Texas]	ziP נסט Ito-generate based on Phys	de: [12345-[6789]]	nd Statal
Coun	iy. [Tarrant] { <i>trii</i> s <i>wiii au</i>	no-generale based on Frigs	sicai Address Zip Code ai	nu State)
Home Phone Numb	er: [123-456-7890]	Cell Phone Numb	er: [456-123-7899]	
Daytime Phone Numb		Fax Phone Numb	•	
Preferred Contact Numb				
	[Daytime]			
Best Time to Ca	all: [AM]	Ema	ail: [john.doe@email.co	om]
Marital State	ıs: ○ Married ○ Single	O Common Law {this wil	I only he an ontion IF the	state recognizes
Maritai State		age/unity}] [O Domestic Pa		
		s as a legal marriage/unity}		
[If "Common Law":	· ·	0 0 11	•	
Is there any legal imped		including but not limited		
	either party that has n	ot been legally terminated	d by death or divorce?	O Yes O No
Δ.	o vou living in a hughan	nd and wife relationship e	valueiva of all others?	O Voc. O No
Al	e you living in a nusban	iu anu whe relationship e	If "Yes" –	O res O No
	Indicate the dat	te you entered into your o		[MM/DD/YY]
		In what State did yo	u reside on that date?	[state]]
_				0.1/
Are you pr	esented and known thro	oughout your community	as husband and wife?	O Yes O No
	Are you jointly	responsible for each other	er's common welfare?	O Yes O No]
SSN: [[123-45-6789] G e	ender: • Male • Fema	ale	
Data of Bind	00/04/4004]	Ama. [44] (-:::	tion boood on IID-1 1D	علاما الملاسة
Date of Birth: [08/04/1994]	Age: [14] {auto-calcula date}	tion based on "Date of B	ıπn" ana today's



Birth	olace:	[state]	Height:	[5 feet	10	inches]
-------	--------	---------	---------	---	--------	----	--------	---

Other: [i.e. Russia] Weight: [150]

> Occupation/Duties: [none]

Is Applicant a U.S. Citizen? O Yes O No [If "No", explain: [explanation]

[months][years] How long in the U.S.?

Residency Status: O Work Permit O Visa O Other]

[If "Visa", Type of Visa: [TYPE]

Expiration Date: [MM/DD/YY] [N/A][If "Other", explain: [explanation]]

[Guardian Information]

First Name: [John] Middle Initial: [C] Last Name: [Doe] Suffix:

Relationship: **Phone Number:** [123-456-7890] [Uncle] Mailing Address: [1234 Anywhere St] **City:** [Ft. Worth]

Apt or Suite Number: [Apt. 123] State: [Texas] **ZIP Code:** [12345-[6789]]

{If "No":}

[APPLICANT DEMOGRAPHICS]

Middle Initial: First Name: [John]

Last Name: [Doe] Suffix:

Physical (no PO Box) Address: [1234 Anywhere St]

[Apt. 123] Apt or Suite Number:

City: [Ft. Worth]

ZIP Code: [12345-[6789]] State: [Texas]

County: [Tarrant] {this will auto-generate based on Physical Address Zip Code and State}

Home Phone Number: [123-456-7890] **Cell Phone Number:** [456-123-7899] **Daytime Phone Number:** [098-765-4321] **Fax Phone Number:** [987-654-4321]

Preferred Contact

Number: [Davtime]

Best Time to Call: Email: [john.doe@email.com] [AM]

Marital Status: ● Married ○ Single [○ Common Law {this will only be an option IF the state recognizes this as

a legal marriage/unity}] [O Domestic Partnership {this will only be an option IF the state

recognizes this as a legal marriage/unity}]

[If "Common Law":

Is there any legal impediment to your marriage, including but not limited to, a prior marriage of

either party that has not been legally terminated by death or divorce? O Yes O No

Are you living in a husband and wife relationship exclusive of all others? O Yes O No

[If "Yes" -

Indicate the date you entered into your common law marriage: [MM/DD/YY]

> In what State did you reside on that date? [state]]

Are you presented and known throughout your community as husband and wife? O Yes O No

> Are you jointly responsible for each other's common welfare? O Yes O No 1



SSN: Date of Birth:	[123-45-6789] [08/04/1976]	Gender: ● Male ○ Female Age: [32] {auto-calculation based on "Date of Birth" and today's date}
Birthplace: Other:	[state] [i.e. Russia]	Height: [6 feet 2 inches] Weight: [220]
ŀ	Occupation/Duties: licant a U.S. Citizen? [If "No", explain: low long in the U.S.? Residency Status: "Visa", Type of Visa: Expiration Date: [If "Other", explain:	[none] O Yes O No [explanation] [months][years] O Work Permit O Visa O Other] [TYPE] [MM/DD/YY] [N/A]] [explanation]]
Apt or Suite Numl	ess: [1234 Anywhere section of the s	St] ZIP Code : [12345-[6789]]
[Coverage Information] Req	uest for Special Effect	tive Date: [01/15/2009] {If Applicant does not have a special request, then this will be blank}
		MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/oi r, form 26023-IP (5/07) AR) only (they are applicable for all other plans}
father? O Yes O No		Id (even if not proposed for insurance) now pregnant or an expectant pectant person, his or her relationship to the Primary Applicant and the
	ility, in the process of Yes O No	ild (even if not proposed for insurance) being tested for or receiving f adoption or surrogacy (with anyone, whether or not this person is
3. Has the Applicant used to {If "Yes":} [Please provide sr [details]]		e past twelve (12) months? • Yes • No over past twelve months:
O Yes O No		Int currently have a suspended or revoked Driver's License? License suspension or revocation.
5. Has the Applicant ever re { <i>If</i> "Yes":} [Please indicate the [details]]		or driving while under the influence (e.g. DWI or DUI)? • Yes • No ad DUI.
6. Has the Applicant ever be	en convicted or prose	ecuted for any criminal activity? O Yes O No



{If "Yes":} [Please describe	and offense and indice	to the detail	(a) of propagation
[details]	sacii onense and muica	ite the date((s) or prosecution.
[details]]			
Income and Disability Detail]		
{The following questions are	only applicable if Prim	nary or Spou	use Applicant(s) chose the "Income Protection Plan" (Accident-
			6-C]) or the "Income Protection Plus Plan" (Disability Income
Insuranc	ce Certificate) (Form # [[25915-C]);	not applicable for Dependent Applicant(s).}
	ently have Disability	Income Ins	surance (either through your employer or as an individual
policy)? O Yes O No	_		
	ompany name]		
Monthly Bene			
	eriod: [time period]		
Length of Co	verage: [six months]		
{If "Yes"}			
2. Are you currently disable	d or receiving disabil	ity hanafits	2 O Yes O No
2. Are you currently disable	a or receiving disabil	ity beliefits	3: 3 les 3 No
3. What is your annual gros	s income? [\$\$\$\$\$\$	\$\$]	
-		_	
4. How many hours per wee	k do you work? [55]	Hours	
F. Tall up about your accum	ation and describe ve	opodifio	siah dutian
5. Tell us about your occup			s job duties.
	on: [route sales manag		ah mayy alianta, daliyar maada ta ayiating aliantal
Duties: [mana	age sales on delivery ro	oute; establis	sh new clients; deliver goods to existing clients]
6 As part of your normal	activities do vou sr	end more	than 25% performing manual labor/duties such as lifting,
			s over 10 pounds? O Yes O No
	paorining arrayor barry	ing objects	
FAMILY MEMBERS			
Family Member 1]			
First Name:	[Jane]		Middle Initial: [A]
Last Name:	[Doe]		Suffix:
SSN:	[123-45-6789]		
Date of Birth:	[08/19/1978]	Age:	[30] {auto-calculation based on "Date of Birth" and today's
24.0 0. 2	[00/10/10/0]	7.90.	date}
Relationship	[spouse]	Gender:	
Height:	[5 feet 4 inches]	Weight:	[130]
Birthplace:	[state]	Other:	[i.e. Russia]
	[]		[
	Occupation/Duties:	[working v	woman]
Is App	licant a U.S. Citizen?	O Yes	O No
	[If "No", explain:	[explanation	ion]
H	low long in the U.S.?	[months][y	years]
	Residency Status:	O Work P	Permit O Visa O Other]
[If	"Visa", Type of Visa:	[TYPE]	
	Expiration Date:	[MM/DD/Y	YY] [N/A]]
	[If "Other", explain:	[explanation	ion]]
Same address as Prir	nary Applicant? O	res O No	o {If "No", will ask for Family Member's mailing address}
[Additional Detail]			
			ntal Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or
the "MEGA Vision Plan" ((Vision Insurance Polic	y, form 2602	23-IP (5/07) AR) only (they are applicable for all other plans)



1. Has the Applicant used tobacco products in the past twelve (12) months? • Yes • No {If "Yes":} [Please provide smoking/tobacco history over past twelve months: [details]]
2. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License? O Yes O No
<pre>{If "Yes":} [Please indicate the reason(s) for Driver's License suspension or revocation. [details]]</pre>
3. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? • Yes • No {If "Yes":} [Please indicate the date for each DWI and DUI. [details]]
4. Has the Applicant ever been convicted or prosecuted for any criminal activity? • Yes • No {If "Yes":} [Please describe each offense and indicate the date(s) of prosecution. [details]]
[Income and Disability Detail] {The following questions are only applicable if Primary or Spouse Applicant(s) chose the "Income Protection Plan" (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) or the "Income Protection Plus Plan" (Disability Income Insurance Certificate) (Form # [25915-C]); not applicable for Dependent Applicant(s).}
1. Does the Applicant currently have Disability Income Insurance (either through your employer or as an individual policy)? O Yes O No Company: [company name] Monthly Benefit: [\$\$\$\$] Elimination Period: [time period] Length of Coverage: [six months]
{If "Yes"}2. Are you currently disabled or receiving disability benefits? ○ Yes ○ No
3. What is your annual gross income? [\$\$\$\$\$\$\$\$]
4. How many hours per week do you work? [55] Hours
5. Tell us about your occupation and describe your specific job duties. Job Description: [route sales manager] Duties: [manage sales on delivery route; establish new clients; deliver goods to existing clients]
6. As part of your normal activities, do you spend more than 25% performing manual labor/duties such as lifting, bending, stooping, pulling, pushing and/or carrying objects over 10 pounds? • Yes • No



mily Member 2]
First Name: [Baby] Middle Initial: [B]
Last Name: [Doe] Suffix:
SSN : [123-45-6789]
Date of Birth: [01/17/2006] Age: [2] {auto-calculation based on "Date of Birth" and today's date}
Relationship [dependent] Gender: ● Male O Female
Height: [3 feet 1 inches] Weight: [42]
Birthplace: [TX] Other: [i.e. Russia]
Occupation/Duties: [none]
Is Applicant a U.S. Citizen? O Yes O No
[If "No", explain: [explanation]
How long in the U.S.? [months][years]
Residency Status: O Work Permit O Visa O Other]
[If "Visa", Type of Visa: [TYPE]
Expiration Date: [MM/DD/YY] [N/A]]
[If "Other", explain: [explanation]]
Same address as Primary Applicant? O Yes O No {If "No", will ask for Family Member's mailing address}
Is this an adoption/guardianship? • Yes • No
Is Dependent Applicant between the ages of 19 and 24? • Yes • No
Is this Applicant a full-time student? ● Yes ○ No
[[If "Yes",] Name of School: [Great University]]
Explain: [details]
Is this Applicant incapable of self-sustaining employment by reason of
mental retardation or physical handicap and chiefly dependent on the
Primary Applicant for support and maintenance? • Yes • No
Times, Applicant to Support and manifestation of 100 of 100
dditional Detail]
he following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or
the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans)
the mean read and the and the analysis of the plane,
Has the Applicant used tobacco products in the past twelve (12) months? • Yes • No
"Yes":} [Please provide smoking/tobacco history over past twelve months:
etails]]
Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License?
Yes O No
"Yes":} [Please indicate the reason(s) for Driver's License suspension or revocation.
etails]]
Has the Applicant ever received any citations for driving while under the influence (e.g. DML or DIMA O.V.)
Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? • Yes • No
"Yes":}[Please indicate the date for each DWI and DUI.
etails]]
Has the Applicant ever been convicted or prosecuted for any criminal activity? • Yes • O No
"Yes": [Please describe each offense and indicate the date(s) of prosecution.
etails]

CHOICE OF COVERAGE

The following [Certificates] [Policies] are underwritten by The Chesapeake Life Insurance Company:

[Plan Name]	[Applicant(s)]	[Description]	[Monthly Premium]
[Chesapeake ESSENTIAL Fit	[John Doe]	[Calendar Year Deductible:	[\$\$\$.\$\$]



	STATEMEN	STATEMENT OF VARIABILITY					
(Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (EFIL)]	[Jane Doe] [Baby Doe]	[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network \$5,000 per Family, In-Network / \$10,000 per Family, Out-of-Network]	[Incl.]				
		Person, Out-of-Network \$10,000 per Family, In-Network / \$20,000 per Family, Out-of-Network]					
		[\$7,500 per Person, In-Network / \$15,000 per Person, Out-of-Network \$15,000 per Family, In-Network / \$30,000 per Family, Out-of-Network]					
		[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network [\$20,000 per Family, In-Network / \$40,000 per Family, Out-of-Network]					
		[\$15,000 per Person, In-Network / \$30,000 per Person, Out-of-Network [\$30,000 per Family, In-Network / \$60,000 per Family, Out-of-Network]					
		[\$20,000 per Person, In-Network / \$40,000 per Person, Out-of-Network [\$40,000 per Family, In-Network / \$80,000 per Family, Out-of-Network]]					
		Coinsurance: [100% In-Network / 70% Out-of-Network] [90% In-Network / 60% Out-of-Network] [80% In-Network / 50% Out-of-Network] [70% In-Network / 50% Out-of-Network]					
		Calendar Year / Lifetime Maximum: [\$1,000,000 / \$2,000,000] [\$1,000,000 / \$4,000,000] [\$2,000,000 / \$8,000,000]					
		[Coinsurance Maximum (per Calendar Year): [\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network \$5,000 per Family, In-Network / \$10,000 per Family, Out-of-Network]					
		[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network \$10,000 per Family, In-Network / \$200,000 per Family, Out-of-Network]					

[\$10,000 per Person, In-Network / \$20,000



per Person, Out-of-Network \$20,000 per Family, In-Network / \$40,000 per Family, Out-of-Network]

[\$15,000 per Person, In-Network / \$30,000 per Person, Out-of-Network \$30,000 per Family, In-Network / \$60,000 per Family, Out-of-Network]

Option of Network:

[023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]

[Chesapeake CLASSIC Fit (Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (CFIL)] [John Doe] [Jane Doe] [Baby Doe]

[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible:

[\$\$\$\$.\$\$]

[Incl.]

[Date: [MM/DD/YY]]

[\$1,000 per Person, In-Network / \$2,000 per Person, Out-of-Network]

[\$1,500 per Person, In-Network / \$3,000 per Person, Out-of-Network]

[\$2,000 per Person, In-Network / \$4,000 per Person, Out-of-Network]

[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network]

[\$3,000 per Person, In-Network / \$6,000 per Person, Out-of-Network]

[\$3,500 per Person, In-Network / \$7,000 per Person, Out-of-Network]

[\$4,000 per Person, In-Network / \$8,000 per Person, Out-of-Network]

[\$4,500 per Person, In-Network / \$9,000 per Person, Out-of-Network]

[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network]

[\$7,500 per Person, In-Network / \$15,000 per Person, Out-of-Network]

[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network]]

Coinsurance:

[100% In-Network / 80% Out-of-Network] [90% In-Network / 70% Out-of-Network] [80% In-Network / 60% Out-of-Network] [70% In-Network / 50% Out-of-Network]

Calendar Year / Lifetime Maximum:

[\$1,000,000 / \$2,000,000] [\$1,000,000 / \$4,000,000] [\$2,000,000 / \$8,000,000]

[Coinsurance Maximum (per Period of Treatment):



[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network]]

[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network]

[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network]]

Option of Network:

[023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]

[Chesapeake BASIC Fit (Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26220 PPO-IP (03/09) AR] (BFIL)] [John Doe] [Jane Doe] [Baby Doe]

[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible:

[\$\$\$\$.\$\$]

[Incl.]

[Date: [MM/DD/YY]]

[\$2,000 per Person, In-Network / \$4,000 per Person, Out-of-Network]

[\$2,500 per Person, In-Network / \$5,000 per Person, Out-of-Network]

[\$3,000 per Person, In-Network / \$6,000 per Person, Out-of-Network]

[\$3,500 per Person, In-Network / \$7,000 per Person, Out-of-Network]

[\$4,000 per Person, In-Network / \$8,000 per Person, Out-of-Network]

[\$4,500 per Person, In-Network / \$9,000 per Person, Out-of-Network]

[\$5,000 per Person, In-Network / \$10,000 per Person, Out-of-Network]

[\$5,500 per Person, In-Network / \$11,000 per Person, Out-of-Network]

[\$7,500 per Person, In-Network / \$15,000 per Person, Out-of-Network]

[\$10,000 per Person, In-Network / \$20,000 per Person, Out-of-Network]]

Coinsurance:

[80% In-Network / 60% Out-of-Network] [70% In-Network / 60% Out-of-Network] [70% In-Network / 50% Out-of-Network]

Lifetime Maximum:

[\$500,000] [\$1,000,000]

Hospital Inpatient & Miscellaneous / Inpatient Surgeon Maximum Benefit Amount:

[\$7,500 / \$3,000] [\$10,000 / \$4,000] [\$15,000 / \$6,000]



		[Combined Visit Limitation (per Person, per Calendar Year): [15] [20] [30]]	
[Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form # CH-26224-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	[Copayment][Facility Fee]	[\$\$\$\$.\$\$] [Incl.]
		Maximum Benefit Amount (per Person, per Calendar Year): [\$500] [\$1,000] [\$1,500]	
[Outpatient Accident Expense Benefit Rider (Form # CH-26221-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	Copayment (In-Network and Out-of-Network): [\$50] [\$100] [\$150]	[\$\$\$.\$\$] [Incl.]
		Visit Limitation (per Person, per Calendar Year): [unlimited] [2] [4]	
[Physician Office Services Benefit Rider (Form # CH-26223-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	Copayment (per Person, per Visit): [\$25 In-Network / \$50 Out-of-Network] [\$50 In-Network / \$100 Out-of-Network] [\$75 In-Network / \$150 Out-of-Network]	[\$\$\$\$.\$\$] [Incl.]
		Option of Network: [023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]	
		[\$20,000 / \$8,000] [\$25,000 / \$9,000]	
		[\$15,000 / \$6,000] [\$17,500 / \$7,000]	
		[\$7,500 / \$3,000] [\$10,000 / \$4,000] [\$12,500 / \$5,000]	
		Outpatient Surgery Facility / Outpatient Surgeon Maximum Benefit Amount: [\$3,750 / \$1,000] [\$5,000 / \$2,000]	
		[\$40,000 / \$16,000] [\$50,000 / \$18,000]	
		[\$25,000 / \$10,000] [\$30,000 / \$12,000] [\$35,000 / \$14,000]	
		[\$20,000 / \$8,000]	



[Continued Care Benefit Rider (Form # CH-26225-IR (03/09) AR)]	[John Doe] [Jane Doe] [Baby Doe]		[\$\$\$.\$\$] [Incl.]
[Outpatient Diagnostic Services Benefit Rider (Form # CH-26226-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	[[Copayment][Facility Fee]	[\$\$\$\$.\$\$] [Incl.]
		[Maximum Benefit Amount (per Person, per Day): [\$500] [\$750] [\$1,000] [\$1,250] [\$1,500]]	
		[Maximum Benefit Amount (per Person, per Calendar Year): [\$2,500] [\$3,000] [\$5,000] [\$7,500]]	
[Covered Services Extension	[John Doe]		[\$\$\$.\$\$]
Rider (Form #	[Jane Doe]		[Incl.]
CH-26228-IR (03/09))]	[Baby Doe]		
[Rate Guarantee Rider	[John Doe]	Guarantee Level:	[\$\$\$.\$\$]
(Form # CH-26205-IR (08/08))]	[Jane Doe] [Baby Doe]	[24] [36] months	[Incl.]
[Pregnancy/Childbirth Benefit	[John Doe]	Maximum Benefit Amount	[\$\$\$.\$\$]
Rider (Form #	[Jane Doe]	(per pregnancy/childbirth):	[Incl.]
[CH-26213-IR (03/09) AR])]	[Baby Doe]	[\$1,000] [\$2,000] [\$3,000] [\$4,000] [\$6,000]	
Prescription Drug Expense Rider	[John Doe]	Maximum Benefit	[\$\$\$.\$\$]
(Form # [(CH-26214-IR (03/09) AR)]]	[Jane Doe] [Baby Doe]	(per person, Calendar Year): [\$1,500][\$2,000] [\$5,000]	[Incl.]
		Generic / Brand Drug Deductible (per Person, per Calendar Year): [[\$0 / \$50] [\$0 / \$250]]	
		Retail: Generic Preferred Drugs, [30] day supply: [100%] less [\$5] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$15] copayment Brand Preferred Drugs, [30] day supply discount: [50%] Brand Non-Preferred Drugs, [30] day supply	
		discount: [25%][50%] Mail-Order: Generic Preferred Drugs, [90] day supply: [100%] less [\$15] copayment	



Generic Non-Preferred Drugs, [90] day supply: [100%] less [\$45] copayment Brand Preferred Drugs, [90] day supply discount: [50%]

Brand Non-Preferred Drugs, [90] day supply discount: [25%]

[Prescription Drug Expense Rider (Form # [(CH-26222-IR (03/09) AR)]] [John Doe] [Jane Doe] [Baby Doe] Maximum Benefit

(per Person, per Calendar Year):

[\$500] [\$1,000] [\$1,500]

[\$\$\$.\$\$]

[Incl.]

[\$\$\$\$.\$\$1

[Incl.]

[Date: [MM/DD/YY]]

Deductible

(per Person, per Calendar Year): [\$50] [\$75] [\$100] [\$150] [\$250]

Retail:

Generic Preferred Drugs, [30] day supply: [100%] less [\$5] [\$10] [\$15] copayment
Generic Non-Preferred Drugs, [30] day supply: [100%] less [\$20] [\$25] [\$30] copayment
Brand Name Drugs, [30] day supply discount: [25%]

Mail-Order:

Generic Preferred Drugs, [90] day supply: [100%] less [\$10] [\$20] [\$30] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [\$40] [\$50] [\$60] copayment Brand Name Drugs, [90] day supply discount: [25%]

The following Certificates/Policies are underwritten by The MEGA Life and Health Insurance Company:

[MEGA Vision Plan (Vision Insurance Policy) (Form # [(26023-IP (5/07) AR)]) (VSIN)] [John Doe] [Jane Doe] [Baby Doe]

NETWORK: Deductible: [\$0]

Comprehensive Eye Exam: [100%]
Corrective Spectacle Lenses: [100%]
Corrective Contact Lenses (Non-Disposable or

Disposable): [\$40] Corrective Contact Lenses (Therapeutic):

[100%] Frames: [Not Covered]

Frames: [Not Covered]
Contact Lens Fitting: [Not Covered]
Follow-Up Visits: [Not Covered]

NON-NETWORK: Deductible: [\$0]

Comprehensive Eye Exam: [\$30] Corrective Spectacle Lenses: [75%]

Corrective Contact Lenses (Non-Disposable or

Disposable): [\$30]

Corrective Contact Lenses (Therapeutic): [75%]

Frames: [Not Covered]



		Contact Lens Fitting: [Not Covered] Follow-Up Visits: [Not Covered]	
[MEGA Bronze (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLB)]	[John Doe] [Jane Doe] [Baby Doe]	[BRONZE (Option A-Diagnostic & Preventive): Deductible: [\$0]]	[\$\$\$.\$\$] [Incl.]
[MEGA Silver (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLS)]		[SILVER (Option B-Premiere): Deductible (per person, per year): [\$100] Benefit Maximum (per person, per year): [\$1000]]	
[MEGA Gold (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLG)]		[GOLD (Option C-Deluxe): Deductible (per person, per lifetime): [\$100] Benefit Maximum (per person, per year): [\$1200]	
		Orthodontics Benefit Maximum (per person, per month): [\$50] Orthodontics Benefit Maximum (per person, per lifetime): [\$1200]	
[MEGA CancerWise (Cancer Benefit Policy) (Form # [(26055-IP (5/07) AR)]) (ECAN)]	[John Doe] [Jane Doe] [Baby Doe]	First Diagnosis Cancer Benefit Amount (per person, per lifetime): [\$10,000] [\$20,000] [\$30,000] [\$40,000] [\$50,000]	[\$\$\$\$.\$\$] [Incl.]
[Income Protection (Accident- Only Disability Income Insurance Certificate) (Form # [25916-C]) (DIGP)]	[John Doe] [Jane Doe]	Monthly Indemnity Benefit (per disabled person): [\$500] [\$1000] [\$1500] [\$2000]	[\$\$\$\$.\$\$] [Incl.]
		Elimination Period (per disabled person): [14] [30] days	
[Income Protection Plus (Disability Income Insurance Certificate) (Form # [25915-C]) (DSGP)]	[John Doe] [Jane Doe]	Monthly Indemnity Benefit (per disabled person): [\$500] [\$1000] [\$1500] [\$2000]	[\$\$\$\$.\$\$] [Incl.]
(D3GF)]		[Blue Collar: Yes]	
		[White Collar: Yes]	
[Waiver of Premium Benefit Rider (Form # [25917])]	[John Doe] [Jane Doe]		[\$\$\$\$.\$\$] [Incl.]
[Endorsement Return of Premium Benefit (Form # [25918])]	[John Doe] [Jane Doe]		[\$\$\$.\$\$] [Incl.]
[Critical Care Plus (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C]) (Cl01)]	[John Doe] [Jane Doe] [Baby Doe]	First Occurrence Benefit Amount (per person, per lifetime): [\$10,000] [\$15,000] [\$20,000] [\$30,000] [\$40,000] [\$50,000] [\$60,000]	[\$\$\$\$.\$\$] [Incl.]



[MEGA Accident Advantage	[John Doe]	Accidental Injury Benefit Amount, per person,	[\$\$\$\$.\$\$]
(Accidental Injury Only Insurance	[Jane Doe]	per year:	[Incl.]
Certificate) (Form # [26038-C]) (ASLG)]	[Baby Doe]	[\$5000] [\$10,000] [\$15,000] [\$25,000]	
[Accident Expense Insurance	[John Doe]	Deductible, per person, per occurrence:	[\$\$\$.\$\$]
Plan (Accident Catastrophic Expense Plan Certificate of	[Jane Doe] [Baby Doe]	[\$0] [\$600] [\$1,200] [\$2,400]	[Incl.]
Insurance) (Form # [25314]) (IA08)	[200) 200]	Maximum Benefit, per person, per occurrence: [\$6,000] [\$12,000] [\$24,000]	
		Coinsurance: [100%] [80%] [50%]	
[Accident Expense Benefit Rider (Form # [25096])]	[John Doe] [Jane Doe] [Baby Doe]	Deductible, per injury: [\$0] [\$100]	[\$\$\$\$.\$\$] [Incl.]
	[,]	Maximum Benefit, per injury [\$600] [\$1,200]	
[Direct Benefit (Hospital	[John Doe]	Daily Benefit Amount (per person):	[\$\$\$.\$\$]
Confinement Indemnity Certificate) (Form # [25874-C]) (DB01)]	[Jane Doe] [Baby Doe]	[\$100] [\$200] [\$250] [\$300] [\$400] [\$500] [\$1,000] [\$1,500]	[Incl.]
[023-Private Health Care Systems (PHCS)]			[\$\$\$.\$\$] [Incl.]
[074-Texas True Choice] [075-HealthSmart]			
[Certificate][Policy] Fee			[\$\$\$.\$\$] [Incl.]
		Total Estimated Recurring Payment:	[\$\$\$.00]
		Total Estimated Recurring Payment:	[\$\$\$\$.00]
		Total initial Payment:	[ΦΦΦΦ.ΟΟ]

The estimated premium is provided prior to review by the Underwriting Department and may change after underwriting review. You will be notified if there is any change to the estimated recurring payment as a result of underwriting review.



The following section is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans)

PHYSICIAN DETAILS (Name of current Physician and any other Physician or specialist seen in the past 12 months)

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Primary Applicant: [John Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited

ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY]

Reason(s)? [reason]

Result(s)? [results]

Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Spouse Applicant: [Jane Doe]

Physician/Specialist Name: [James Brown, MD]

Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code**: [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]

Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Dependent Applicant: [Baby Doe]

Physician/Specialist Name: [Baby Doctor, MD]
Phone Number: [123-456-7890]

Address Line 1: [1234 Anywhere Street]

Address Line 2: [Suite ABC]

City: [My Town]

State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care

Center/Hospital? [MM/YYYY]

Reason(s)? [reason]

Result(s)? [results]

Recommendation(s)? [recommendations]



[John Doe] Beneficiary Information Details

First Name: [Jane]

BENEFICIARY INFORMATION

BENEFICIARY 1

STATEMENT OF VARIABILITY

{The following section is only applicable if "10 Year Term Life Plan" (Renewable Term Life Insurance Plan Certificate, form 25919-IP (1/09) TX is chosen. This section will replicate for every Applicant that applied for the Renewable Term Life Insurance Plan Certificate.

Middle Initial: [A]

	Name: [Doe]	•		Suffi		
	Name: [Doe]					
Beneficiary Relation	•	J		Percentag	e: [XXX%]	
1	Other:					
	City: [Fabu	ılous]				
	State: State	el -				
	-	i5-9876]				
DENIETICIADY 2	210. [1204	10-3010]				
BENEFICIARY 2		,				
	Name: [Baby	-		Middle Initia		
Last I	Name: [Doe]			Suffi	X:	
Beneficiary Relation	nship: [Son]			Percentag	e: [XXX%]	
•	Other:					
	City: [Fabu	ilouel				
	State: [State					
	Zip : [1234	l5-9876]				
PRIOR COVERAGE						
	is NOT applic	ahla for the "MEI	CA Dental Pla	n" (Dental Insurance Polic	v form 26000-IE	2 (1/08)) and/or the
	Plan" (Vision	insurance Policy	, TORM 26023-1	P (5/07) AR) only (it is app	nicable for all oth	ner <u>pians}</u>
MEDICARE/MEDICAID						
Is any Applicant eligibl	le for or curre	ntly covered un	der Medicare	or Medicaid? • Yes	O No	
' ''		-				
[If "Yes"	who?	Ra	ason			
<u> </u>	•					
	O [John Doe]		[Medical]			
	O [Jane Doe]	•] [Medical]			
	O [Baby Doe]	[Financial]	[Medical]			
1						
CURRENT HEALTH INS	SURANCE					
During the past two ve	ears, has any	person to be i	insured had i	nsurance declined, pos	poned, had a v	waiver applied, or
				e or had such insurance		
charged additional pre	illiulli loi lile,	disability of fie	aitii iiisuraiic	e or mad such insurance	rescillueu : C	162 2 100
		_		_		
If "Yes", who?		Date		Reason		e of Company
[J	ohn Doe]	[12/200	00]	[XYZ Reason]	[AE	3C Insurance]
	ane Doe	05/200		[LMNOP Reason]		EF Insurance
		[-,	[<u>.</u> – -	
Doos any Applicant of		haalth inaura	noo or boo	nny Annliaant had haal	h ingurance u	ithin the neet 10
		e neam insura	nce or has a	any Applicant had heal	in insurance w	nthin the past 12
months? O Yes O No						
[If "Yes", has covera	ige been in for	ce within the pas	t 60 days? 🔾	Yes O No] [If "No", date	of cancellation:	[MM/YYYY]]
If "Yes", who?	Group or Indi	vidual Name	of Company	Certificate/Policy	Type of	Date of Issue
" '66 , "	•		or company	Number		Date of locae
l ,	Coverage				Coverage	FO = (0 0 0 = 1
[Jane Doe]	[Group]	[HIJ	Insurance]	[ABC12345] [A	Accident-Only]	[05/2007]
[{If "Yes"} Will existing	g health cove	rage be replace	d or changed	if proposed health cove	rage is issued?	? O Yes O No 1
If "Yes", w		5	On Issue		Date of Can	
			[Yes]	•	[10/20	
[Jane Do	<u>,c]</u>		[168]		[10/20	00
(VAR STMT) CH/MG-25	098-eAPP (03	/09) AR	16		77	Date: [MM/DD/YY]]
(VAR STIVIT) CIT/IVIG-23		700) / 11 1	10		L-	



CURRENT LIFE INSURANCE Does any Applicant currently have life insurance or annuities? • Yes • No	0
[If "Yes", who?	
Will the insurance applied for replace or otherwise reduce in value any life in O Yes O No	nsurance or annuities now in force?
[If "Yes", details: [details]	
Are you considering discontinuing making premium payments, surrendering terminating your existing policy/certificate or contract? • Yes • No	, forfeiting, assigning to the insurer, or otherwise
Are you considering using funds from your existing policies/certificates of policy/certificate or contract? • Yes • No	or contracts to pay premiums due on the new
[If you answered "Yes" to either of the above questions, list each existing portion (include the name of the insurer, the insured or annuitant, and the and whether each policy/certificate or contract will be replaced or used as a second contract.	policy/certificate or contract number if available)
	ACT OR REPLACED (R) OR FINANCING (F)
	23456] R
{The following questions are NOT applicable for the "MEGA Dental Plan" (Denta the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR)	
MEDICAL QUESTIONS Have you or any Applicant EVER had symptoms, been diagnosed, rece 1. Hazardous Activities or Sports - does Any Applicant to be insured engage in any hazardous sport or activity? [If "Yes", is it professionally or for recreation?	O Yes O No
Select all Applicants this question applies to:	○ [John Doe] ○ [Jane Doe]○ [Baby Doe]
2. Heart or Cardiovascular Conditions/Disorders including but not limited to - Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system?	
Select all Applicants this question applies to:	○ [John Doe]○ [Jane Doe]○ [Baby Doe]
3. Endocrine Disorders including but not limited to – Diabetes (high blood sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity?	



Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
4. Blood Disorders including but not limited to - Blood or spleen disorder, including anemia, leukemia, high cholesterol, or hyperlipidemia?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
5. Gynecological Disorders including but not limited to – male or female reproductive organ disorder or disease, including breast disorder or augmentation?	O Yes O No
augmentations	3 103 3 110
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
6. Cancer / Tumor or any benign or malignant growths, including but not limited to - Cancer, cyst, tumor, or neoplasm?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
7. Respiratory Disorders including but not limited to - Respiratory disorder,	
including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea, or breathing problems?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
8. Urinary Tract Disorders including but not limited to - Kidney, bladder, urinary tract, stones, or prostate disorders?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
9. Digestive Tract Disorders including but not limited to – GERD	-
(gastroesophageal reflux disease), Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis, hepatitis, or pancreatitis?	O Yes O No
Coloct all Applicants this guestion applies to	O [John Doe] O [Jane Doe]
Select all Applicants this question applies to: 10. Colon Disorders including but not limited to - Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders?	O [Baby Doe] O Yes O No
	O [John Doe] O [Jane Doe]
Select all Applicants this question applies to: 11. Eye, ear, nose, or throat disorders - Eye, ear, nose, or throat disorders?	O [Baby Doe] O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
12. Skin Disorders including but not limited to - Skin disorders, burns,	- , -
lacerations, dermatitis, boils, chronic rashes, or melanoma?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
13. Musculoskeletal Disorders including but not limited to - Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe]



14. Complications of Pregnancy including but not limited to - Cesarean	
section?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
15. Brain Disorders including but not limited to - Epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
16. Mental and Nervous Disorders including but not limited to - Depression, anxiety, alcoholism, alcohol abuse, drug abuse, or drug addiction?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
17. Connective Tissue Disorders including but not limited to - Hodgkin's or Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue disease?	O Yes O No
aloodoo.	
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
18. Abnormal Test Results - Any abnormal results of a cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
19. Symptoms of other Medical Conditions - Abnormal bleeding, swollen or enlarged prostate, or night sweats?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
20. Muscular Disorders - Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of use of any limbs?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
21. AIDS / HIV - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an	
AIDS-related test?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22a. Recent Medical Treatment - WITHIN THE LAST 5 YEARS, have you had	- •
any other medical or surgical advice, hospitalizations, treatment, operations, or testing?	O Yes O No
Select all Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]
22b. Recent Medical Treatment – WITHIN THE LAST 3 YEARS, have you or any Applicant taken, been advised to take, or been prescribed any medication(s)	r



in	cluding any which were not filled?	O Yes O No		
[If "Yes", what condition(s)	is the prescribed medication for?]	[conditions]		
Select all A	Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]		
22c. Recent Medical Treatment – Have you on have additional testing, lab work, surgical or m		O Yes O No		
Select all A	Applicants this question applies to:	O [John Doe] O [Jane Doe] O [Baby Doe]]		
		re/Plus Plan" (Specified Disease/Condition Or		
Major Organ Transplant Certificate) (Form # [25936-C])} 23. Family History - Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or diabetes? 24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? 25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a				
physician for or had symptoms of cancer, a disease of the heart or blood vessels, rer	nal failure, multiple sclerosis, carcino	ma in situ,		
coronary artery by-pass surger	y, coronary angioplasty or Alzheime	r disease? O Yes O No		
{The following section/questions will only be ask	QUESTIONS" section above.}	"Yes" to any of the questions in the "MEDICAL		
[ADDITIONAL HEALTH INFORMATION [secti [Based on previous answers, additional informati Applicant. Note: All of the information you provi	ion is required. Please complete the			
Health Information For: [John Doe]				
[1] HAZARDOUS ACTIVITIES OR SPORTS {C in any hazardous sport or activity"} Select all conditions that apply:	Only asked if Applicant chose "Yes"	to MEDICAL QUESTION #1: "Do you engage		
 Hot Air Ballooning Explosive Transportation Ultra Lights Other Aviation Related Activities 	 Fire Fighting Stunt Flying Experimental Aircraft Flying Flight Testing	 Flying for Hunting Crop Dusting Helicopter / Rotorcraft Flying Other Sports Activities 		
[2] HEART OR CARDIOVASCULAR CONDITIONS/DISORDERS {Only asked if Applicant chose "Yes" to MEDICAL QUESTION #2: "Heart attack, stroke, myocardial infarction"} Select all conditions that apply:				
 Heart Attack Hypertension Coronary Artery Disease Heart-related Arteriogram Disease or Disorder of the Heart 	 Stroke Angina Pectoris Any Form of Heart Surgery Angioplasty Disease or Disorder of the Circ 	 Myocardial Infarction Transient Ischemia Attack (TIA) Coronary Artery Surgery Pacemaker ulatory System 		
[3] ENDOCRINE DISORDERS (Only asked if A goiter")	Applicant chose "Yes" to MEDICAL	QUESTION #3: "Diabetes, hypoglycemia,		



Select all conditions that appl O Diabetes O Obesity	y: O Hypoglycemia	O Goiter	O Thyroid Disorder
[4] BLOOD DISORDERS {Only Select all conditions that appl	asked if Applicant chose "Yes" to	o MEDICAL QUESTION #4: "Blo	ood or spleen disorder"}
O Spleen Disorder	O Anemia	O Leukemia	O Other Blood Disorder(s)
[5] GYNECOLOGICAL DISORI organ disorder"} Select all conditions that appl O Breast Disorder	DERS {Only asked if Applicant ch y: O Reproductive Organ Disorder		ION #5: "Breast or reproductive
[6] CANCER / TUMOR{Only as Select all conditions that appl	ked if Applicant chose "Yes" to N y:	1EDICAL QUESTION #6: "Cance	er, cyst, tumor, or neoplasm"}
O Cancer	O Cyst	O Tumor	O Neoplasm
[7] RESPIRATORY DISORDER including asthma'} Select all conditions that appl O Asthma O Emphysema	(S) {Only asked if Applicant chosey:O BronchitisO Lung Disease	 "Yes" to MEDICAL QUESTION COPD (Chronic Obstructive For Breathing Problems 	
O Other Respiratory Disorder(s))	•	
urinary tract"} Select all conditions that appl O Kidney Disorder	O Urinary Bladder Disorder	ose "Yes" to MEDICAL QUESTIC	ON #8: "Kidney, urinary bladder, O Prostate Disorders
 Other Urinary Tract Disorder([9] DIGESTIVE TRACT DISORI gallbladder"} 	DERS {Only asked if Applicant cl	hose "Yes" to MEDICAL QUEST	ION #9: "Stomach, intestines,
Select all conditions that appl		~ ^	0.1: B : 1
Stomach DisorderPancreas Disorder	O Intestines DisorderO Ulcer	Gallbladder DisordersColitis	Liver DisorderCrohn's Disease
O Cirrhosis	O Enteritis	O Hepatitis	O Pancreatitis
[10] COLON DISORDERS {Onl	ly asked if Applicant chose "Yes" y:	to MEDICAL QUESTION #10: "I	Hernia, hemorrhoids, polyps"}
O Hernia	O Hemorrhoids	O Polyps	O Rectal Disorders
ear, nose"}	ROAT DISORDERS (Only asked	d if Applicant chose "Yes" to ME	DICAL QUESTION #11: "Eye,
Select all conditions that appl O Eye Disorder	y: O Ear Disorder	O Nose Disorder	O Throat Disorder
[12]SKIN DISORDERS <i>{Only as</i> Select all conditions that appl		MEDICAL QUESTION #12: "Skir	n disorders, burns, lacerations"}
O Burns O Chronic Rashes	O Lacerations O Melanoma	O Dermatitis O Other Skin Disorder(s)	O Boils
or leg disorder"}	SORDERS (Only asked if Applica	nnt chose "Yes" to MEDICAL QU	ESTION #13: "Back, spine, arm
Select all conditions that appl O Back Disorder	y: O Spine Disorder	O Arm Disorder	O Leg Disorder



O Arthritis	O Gout	O Bursitis	O Neuritis
[14] COMPLICATIONS OF PR pregnancy and/or Cesarean se Select all conditions that app O Cesarean Section	ection"}		CAL QUESTION #14: "Complications of
fainting"}	y asked if Applicant chose "Yes"	to MEDICAL QUESTION	#15: "Brain disorder, epilepsy,
Select all conditions that app O Epilepsy O Paralysis O Chronic Headaches	Iy: Fainting Spells Tremors Other Brain Disorder(s)	O Dizziness O Palsy	○ Seizures○ Head Injury
[16] MENTAL AND NERVOUS nervous disorder, depression Select all conditions that app	."}	olicant chose "Yes" to ME	DICAL QUESTION #16: "Mental or
O Mental Disorders O Alcoholism	Nervous Disorders Drug Addiction	O Depression	O Anxiety
[17] CONNECTIVE TISSUE DI Hodgkin's Lymphoma"} Select all conditions that app O Hodgkin's Lymphoma O Other Connective Tissue Dis	olly: O Non-Hodgkin's Lymphoma	ant chose "Yes" to MEDIC ○ Cystic Fibrosis	CAL QUESTION #17: "Hodgkin's or Non- O Collagen Disease
	ILTS {Only asked if Applicant chools; Smear (Carcinoembryonic Antigen)	O Abnormal Results from	m PSA (Prostate Specific Antigen)
[19] SYMPTOMS FROM OTHE "Abnormal bleeding, swollen or Select all conditions that app O Abnormal Bleeding	enlarged prostate"}		e "Yes" to MEDICAL QUESTION #19:
[20] MUSCULAR DISORDERS disorder"} Select all conditions that app O Neurological Disease/Disord O Loss of Use of a Limb	oly:		TION #20: "Any neurological disease or • Muscular Disease/Disorder
diagnosed or treated"} Select all conditions that app O AIDS (Acquired Immune Det O AIDS-Related Complex	oly:		e you or any Applicant ever been



Health Information For: [John Doe]

HAZARDOUS ACTIVITIES OR SPORTS

Condition Detail

STATEMENT OF VARIABILITY

{The following section/questions will be asked depending on which condition the Applicant chose in the "CONDITIONS" section above.}

[ADDITIONAL HEALTH INFORMATION [section two]

Based on previous answers, additional information is required. Please complete the requested information for the indicated Applicant. Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.]

Condition: Other Aviation Related Activities (Only asked if Applicant chose "Other Aviation Activities" to

ADDITIONAL HEALTH INFORMATION [section one] question #1}

1. What is the aviation activity you participate in? 2. What type(s) of pilot's license do you currently hold?	[activity] [pilot's license type(s)]	
3. Are you a student pilot or flying instructor? {// "Yes"} [Provide details:	○ Yes ○ No[details]]	
 4. Describe the type of aircraft you normally pilot and/or navigate: 5. How many TOTAL hours flown? 6. How many hours flown in the past 12 months? 7. Do you have a flight instrument rating? {/f "Yes"} [Provide details: 	[description] [total hours] [hours] O Yes O No [details]	
Condition Detail HAZARDOUS ACTIVITIES OR SPORTS Condition: Other Sports Activities {Only HEALTH INFORMATION [secion of the second of the sec	tion one] question #1} s. [details]	rts Activities" to ADDITIONAL
Condition Detail HEART OR CARDIOVASCULAR CONDITIONS/DISC Coronary Artery Surgery; Heart Related Arteriogram; I System in ADDITIONAL HEALTH INFORMATION [see Condition: [Any Form of Heart Surgery] [Disease or Disorder of the H	Disease or Disorder of the Heart; or E ction one] question #2}	Disease or Disorder of the Circulatory Related Arteriogram]
O Blocked Arteries O Valvula		 Cardiomegaly (Enlarged Heart) Carotid Artery Disease Arteritis Arteriovenous (AV) Malformation Cardiomyopathy
{The following question is only application of the condition?	cable if the Applicant selects "Other" t agnosis]	from the list above.}
3. Date condition diagnosed or discovered: [Mi	M/YYYY]	
• • • • • • • • • • • • • • • • • • •	Yes O No M/YYYY]	
5. Have you ever been disabled or O hospitalized?	Yes O No	
(VAR STMT) CH/MG-25098-eAPP (03/09) AR	23	[Date: [MM/DD/YY]



{If "Yes"} [Please	provide additiona	ıl details:			
Disability / Hosp	italization		Start Date	,	Stop Date
[details			[MM/DD/YYY	Y]	[MM/DD/YYYY]
[details			MM/DD/YYY		[MM/DD/YYYY]
[details			MM/DD/YYY		[MM/DD/YYYY] 1
6. Was medication ta	ken or prescribe		O Yes O No	-	
Medication	Dosage/Fred		Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice r		[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice p	7.2	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]
[medication]	[15111g twice	ber day]	[141141/ 1 1]	[141141/ 1 1]	[details]]
Treating Physicia Physician or Facili Nam Phone Numbe Address Line Address Line Cit State and Zi Date See 8. Is there any type medication)? O Y Typ Treating Physicia Physician or Facili Nam Phone Numbe Address Line Address Line Address Line Address Line State and Zi Start Dat Stop Dat Fully Recovered Additional Detail	n: {Applicant will ty [Harris HEB] e: e: [123-456-78] 1: [123 Health 2: y: [City] p: [TX] [12345] n: [MM/YYYY] e of treatment, fes O No {If " e: [type of treat n: {Applicant will ty [Harris HEB] e: e: [123-456-78] 1: [123 Health 2: y: [City] p: [TX] [12345] e: [MM/YYYY] e: [MM/YYYY] d? O Yes O N s: [details]	surgery or Yes"} [Pleatment, surgery have the abid have the abid [90] Street]	r physical therese provide additions or physical the lity to select from a	apy scheduled, onal details: erapy] a drop-down list base	ed on previously entered physician info} recommended or completed (besides ed on previously entered physician info} O No
Scan)? {/f "Yes"} [Please			, -, -	,	
Type of T		ai detalls.	Date of Tes	 st	Results and/or further testing?
[MRI]			[MM/YYYY		[details]
[EKG]			[MM/YYYY	-	[details]
[Lab wor	k1		[MM/YYYY	-	[details]
[Lab Wol	<u>''</u>	<u>l</u>	[141141/ 1 1 1 1	J	[dotallo]]
10. Have you	made a full crecovery?	Yes O No			

Condition Detail

HEART OR CARDIOVASCULAR CONDITIONS/DISORDERS (Only asked if Applicant chose Hypertension in ADDITIONAL



	ST	ATEMENT OF	VARIABILITY	
	ON [section one] question a [Hypertension]	# 3}		
1. Is the high blood p	ressure under control? [If "Yes", for how long?	O Yes O No [length of time]	l	
	istory of heart or circulat "Yes"} [Details: [details]]		uding stroke, hea	art attack, or blocked arteries?
3. Last blood pressur [xxx /xxx] [MM/DD/ [xxx /xxx] [MM/DD/ [xxx /xxx] [MM/DD/	YY];	f known):		
4. Date condition dia	gnosed or discovered:	[MM/YYYY]		
5. Is the condition sti Please supply date		O Yes O No [MM/YYYY]		
6. Have you ever bee hospitalized? //f "Yes"} [Please	n disabled or provide additional details:	O Yes O No		
Disability / Hosp		Start Date		Stop Date
[details] [details]		[MM/DD/YYYY] [MM/DD/YYYY] [MM/DD/YYYY]		[MM/DD/YYYY] [MM/DD/YYYY] [MM/DD/YYYY]]
7. Was medication ta {If "Yes"} [Please	ken or prescribed? provide additional details:	O Yes O No		
Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]]
Treating Physicia Physician or Facil Nam Phone Numbe Address Line Address Line Cir State and Zi	ity [Harris HEB] le: er: [123-456-7890] 1: [123 Health Street]			s) (most current first). ed on previously entered physician info}
9. Is there any type medication)? O Y Typ Treating Physicia Physician or Facil Nam Phone Number	e of treatment, surgery Yes O No {If "Yes"} [Ple e: [type of treatment, surger) in: {Applicant will have the a ity [Harris HEB]	ease provide additi gery or physical the	onal details: erapy]	recommended or completed (besides ed on previously entered physician info)

City: [City]

Address Line 2:



State and Zi	p: [TX] [12345]								
Start Dat	e: [MM/YYYY]								
Stop Dat	e: [MM/YYYY]								
Fully Recovered	d? O Yes O No	0							
Additional Detail	s: [details]								
10. Any type of testin	g performed (i.e	. Lab wor	k, MRI, EKG, Ech	o, O Yes	O No				
Scan)?									
	ase provide additional details:								
Type of T	est		Date of Tes		Results and/or further testing?				
[MRI]			[MM/YYYY		[details]				
[EKG]			[MM/YYYY	-	[details]				
[Lab wor	kj		[MM/YYYY]	[details]]				
11. Have you	made a full orecovery?	Yes O N	0						
Condition Detail									
ENDOCRINE DISORD	ERS (Only aske	d if Applica	nt chose Diabetes	s; Hypoglycemia;	Goiter; Thyroid Disorder; or Obesity in				
ADDITIONAL HEALTH	HINFORMATION	[section o	ne] question #3}		•				
Condition:	[Diabetes] [Hy	poglycem	ia] [Goiter] [Thy	roid Disorder] [0	Obesity]				
1. Do you have or have									
O Glucose Intolerance)		romegaly		O Myxedema				
O Hyperglycemia			Idison's Disease	•	O Juvenile Hypothyroidism				
O Pituitary Tumor			ıshing's Disease o	or Syndrome	 Adrenal Gland Disorder 				
Other		O Cr	etinism						
(The fol	lowing guestion i	only anal	icable if the Applic	cant calacte "Othor	r" from the question above)				
2. What is/was the dia				ani selecis Other	r" from the question above.}				
O Hypothyroidism) Hypoglycemia	Goiter	O Thyroid Nodule				
O Other Condition	O Hyperting	yroidisiii 🤇	riypogiyceiilia	O Goilei	O Thyrola Nodale				
{If "Other Condition"}	[details]	1							
Details:	. [details]								
Details.									
3. Date condition diag	gnosed or disco	vered:	[MM/YYYY]						
4. Is the condition sti	II present?		O Yes O No						
Please supply date	of last occurrenc	e:	[MM/YYYY]						
5. Have you ever bee	n disabled or		O Yes O No						
hospitalized?									
{If "Yes"} [Please		i details:							
Disability / Hosp			Start Date		Stop Date				
[details]			[MM/DD/YYY		[MM/DD/YYYY]				
[details] [MM/DD/YYYY] [MM/DD/YYYY]									
[details]			[MM/DD/YYY	Υ]	[MM/DD/YYYY]]				
6. Was medication ta	kan ar preseribe	A2	O Yes O No						
{If "Yes"} Please			J 163 J 110						
Medication	Dosage/Fred		Start Date	Stop Date	Dr. advised/aware of stopping				
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]				
[medication]	[15mg twice p	, -	[MM/YY]	[MM/YY]	[details]				
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details] [details]]				
[5 35 45 1.]	[g p		[[[actano]]				



		ST	ATEMENT OF V	ARIABILITY					
. Please indicate the ph	ysicians or f	acilities v	who treated you for	the condition(s) (most current first).				
Treating Physician:			ability to select from a d	rop-down list base	d on previously entered physician info}				
Physician or Facility Name:	[Harris HEB]								
Phone Number:	[123-456-789	90]							
Address Line 1:	[123 Health S	Street]							
Address Line 2:									
City:									
State and Zip: Date Seen:									
B. Is there any type of	f treatment,	surgery	or physical therap	y scheduled, r	recommended or completed (beside				
medication)? O Yes					. ,				
			gery or physical thera						
Treating Physician:			ability to select from a d	rop-down list base	d on previously entered physician info}				
Physician or Facility	[Harris HEB]								
Name:									
Phone Number:	[123-456-789								
Address Line 1:	[123 Health S	Streetj							
Address Line 2:	[City]								
City: State and Zip:		[City]							
Start Date:									
Stop Date:	-								
Fully Recovered?		0							
Additional Details:	[details]								
	-			0 V	5 N				
). Any type of testing pe Scan)?	erformed (i.e.	Lab work	k, MRI, EKG, Echo,	O Yes) No				
{If "Yes"} [Please pro	vide addition:	al details:							
Type of Test		ai dotalioi	Date of Test		Results and/or further testing?				
[MRI]			[MM/YYYY]		[details]				
[EKG]			[MM/YYYY]		[details]				
[Lab work]			[MM/YYYY]		[details]]				
0. Have you made a full	I recovery?	O Yes	O No						
Condition Detail									
BLOOD DISORDERS {Oi	nly asked if Ap	oplicant ch	hose Spleen Disordei	; Anemia; or Oth	ner Blood Disorder(s) in ADDITIONAL				
HEALTH INFORMATION									
Condition: [S	pleen Disord	er] [Aneı	mia] [Other Blood D	isorder(s)]					
	Doo	cription:	[description]						
Hos	pitalization re								
поз	Operation r								
	Spo. acion i	-qu ou :	3 100 3 110						
Treatment Information									
	Tr	eatment:	[details]						

Treating Physician: [physician's name]

physician details.

Start Date: [MM/DD/YYYY]

Physician or Facility Name: [name]

(VAR STMT) CH/MG-25098-eAPP (03/09) AR 27 [Date: [MM/DD/YY]]

Enter the treating physician's information below or select previously entered physician name to populate

Stop Date: [MM/DD/YYYY]



	Phone N Address Address	Line 1:	[123-456-7890] [123 Anywhere S [Suite 100] [My Town] [TX]	St.] ZIP Code:					
Prescription Informat									
MEDICATION			EQUENCY	START DAT					
[medication]	-	•	per day]	[MM/YYYY] [MM/YYYY]	[MM/YYYY] [MM/YYYY]				
[medication]	[1001]	ig, once	per day]	[[VIIVI/ 1 1 1 1]	[IVIIVI/ † † † †]				
ADDITIONAL HEALTH		ection o	ne] question #5}		Reproductive Organ Disorder in				
 Do you have or have Endometriosis Disease/Syndrome HPV (Human Papille 	O Can	cer C	Abnormal PAP S	Smears/Dysplasia	O Polycystic Ovarian				
{The 2. What is/was the dia condition?		s only a _l	oplicable if the Ap [diagnosis]	plicant selects "Oti	her" from the list above.}				
{The following que. 3. Please provide add Class of PAP smear [details] Number and date of [details]	litional details for number of abnorm	Abnorm al PAPs	nal PAP smears/I and dates.	Dysplasia:	mears/Dysplasia" from the list above.}				
4. Date condition diag	gnosed or discove	red:	[MM/YYYY]						
5. Is the condition sti Please supply date			O Yes O No [MM/YYYY]						
6. Have you ever bee hospitalized? {\(\text{If "Yes"} \) \[\] Please		etails:	O Yes O No						
Disability / Hosp			Start Date		Stop Date				
[details]			[MM/DD/YYY		[MM/DD/YYYY]				
[details] [details			[MM/DD/YY\ [MM/DD/YY\		[MM/DD/YYYY] [MM/DD/YYYY]]				
7. Was medication ta	ken or prescribed		O Yes O No		[ייסט/יוייין]				
Medication	Dosage/Freque		Start Date	Stop Date	Dr. advised/aware of stopping				
[medication]	[15mg twice per		[MM/YY]	[MM/YY]	[details]				
[medication]	[15mg twice per	day]	[MM/YY]	[MM/YY]	[details]				

8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

[MM/YY]

Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info}

[15mg twice per day]

[medication]

[MM/YY]

[details]]



Physician or Facility Name:	[Harris HEB]						
Phone Number: Address Line 1:							
Address Line 2:	[0:4.1						
City: State and Zip:							
Date Seen:							
Treating Physician: Physician or Facility Name: Phone Number: Address Line 1: Address Line 2: City: State and Zip: Start Date: Stop Date:	O No {If "Y [type of treatr {Applicant will [Harris HEB] [123-456-789 [123 Health S [City] [TX] [12345] [MM/YYYY] [MM/YYYY]	'es"} [Pleament, surghave the about	ase provide ac ery or physica	dditional details: I therapy]		ded or completed (I	
Fully Recovered? Additional Details:	O Yes O No [details])					
10. Any type of testing p Scan)? {If "Yes"} [Please pro	vide additiona						
Type of Test			Date of		Result	ts and/or further testi	ng?
[MRI] [EKG]			[MM/YY [MM/YY	-		[details] [details]	
[Lab work]			[MM/YY	-		[details]]	
11. Have you made a ful	I recovery?	O Yes O	No				
Condition Detail CANCER / TUMOR {Only INFORMATION [section of Condition: [C	ne] question ‡ ancer] [Cyst]	#6} [Tumor]	_	t; Tumor; or Neoplasm	n in ADDITI	ONAL HEALTH	
 Do you have or have y Cancer or Malignant Mo Any Chemotherapy or F Recurrent Occurrences Brain Cancer Other 	elanoma withir Radiation withi	n 5 years		 Metastasis Hodgkin's Disease Lymphoma Non-Hodgkin's Lyr		O Leukemia O Bone Cancer O Sarcoma	
{The follows the diagn condition?		n is only a _l	oplicable if the [diagnosis]	Applicant selects "Otl	her" from th	e list above.}	
3. Date condition diagno	sed or disco	vered:	[MM/YYYY]				
4. Is the condition still particle Please supply date of lease		e:	O Yes O No [MM/YYYY]				



5. Have you ever bee	n disabled or		O Yes O No					
hospitalized?								
{If "Yes"} [Please		l details:	Ctant Data		Cton Data			
Disability / Hosp			Start Date		Stop Date			
[details [details			[MM/DD/YYY [MM/DD/YYY		[MM/DD/YYYY] [MM/DD/YYYY]			
[details	-		[MM/DD/YYY		[MM/DD/YYYY]]			
[dctails	<u>I</u>		ווויסטייייין	1]	[101101/00/1111]			
6. Was medication ta {\lf "Yes"} [Please			O Yes O No					
Medication	Dosage/Fred	quency	Start Date	Stop Date	Dr. advised/aware of stopping			
[medication]	[15mg twice p	, ,	[MM/YY]	[MM/YY]	[details]			
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]			
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]]			
Treating Physicia Physician or Facili Nam Phone Numbe Address Line Address Line Cit State and Zi Date See 8. Is there any type	7. Please indicate the physicians or facilities who treated you for the condition(s) (most current first). Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info} Physician or Facility [Harris HEB] Name: Phone Number: [123-456-7890] Address Line 1: [123 Health Street] Address Line 2: City: [City] State and Zip: [TX] [12345] Date Seen: [MM/YYYY] 8. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? O Yes O No {If "Yes"} [Please provide additional details:							
Fully Recovered Additional Detail	n: {Applicant will ity [Harris HEB] e: er: [123-456-78 1: [123 Health 2: ity: [City] p: [TX] [12345] e: [MM/YYYY] de: [MM/YYYY] ds: [details]	90] Street]		n drop-down list base	ed on previously entered physician info}			
9. Any type of testing Scan)? { f "Yes"} [Please			, MRI, EKG, Echo	o, O Yes	O No			
Type of T			Date of Tes	st	Results and/or further testing?			
[MRI]			[MM/YYYY		[details]			
[EKG]			[MM/YYYY	4	[details]			
[Lab wor	·k]		[MM/YYYY		[details]]			
10. Have you made a	full recovery?	O Yes	O No					

RESPIRATORY DISORDERS (Only asked if Applicant chose Asthma; Bronchitis; Lung Disease; Breathing Problems; or Other



Respiratory Disorder(s) Condition:							spiratory Disorder(s)]	
1. Do you have or have you had a history of: O Lung Transplant O Asthma O Active Tuberculosis O Other C Current Tumor or Neoplasm of Sarcoidosis within 5 years					f the Lung			
{The in a second		n is only a	<i>pplicable</i> [diagnos		olicant selects "O	ther" from the	e list above.}	
{The fo	ollowina auestior	is only an	oplicable if	the App	licant selects "As	thma" from th	ne list above.}	
3. Please provide add							io not abovely	
a. Are you currently usi c. Are you currently usi	ng oral steroids?	O Ye	s O No		mild or seasonal? e you used a stei		O Yes O No	
inhaler?	9				is no longer requ		O Yes O No	
4. Date condition diag	nosed or disco	vered:	[MM/YY	YY]				
5. Is the condition still Please supply date of		e:	O Yes [MM/YY					
6. Have you ever beer hospitalized? {/f "Yes"} [Please p		l details:	O Yes	ON C				
Disability / Hospi		i dotalis.	St	art Date		1	Stop Date	
[details]				DD/YYY			[MM/DD/YYYY]	
[details]				DD/YYY			[MM/DD/YYYY]	
[details]			[MM/	DD/YYY	ΥÏ		[MM/DD/YYYY]]	
7. Was medication tak {If "Yes"} [Please p			O Yes	ON C				
Medication	Dosage/Fred		Start	Date	Stop Date	Dr. ad	vised/aware of stopping	j
[medication]	[15mg twice p	, ,	[MM/		[MM/YY]		[details]	
[medication]	[15mg twice p		[MM/	-	[MM/YY]		[details]	
[medication]	[15mg twice p	er day]	[MM/	YYJ	[MM/YY]		[details]]	
Physician or Facilit Name Phone Numbe Address Line 1 Address Line 2 City State and Zip	Applicant will Applic	have the al	tho treate bility to sele	ed you fo ect from a	or the condition(drop-down list bas	s) (most cur ed on previous	rent first). sly entered physician info}	
medication)? OY	es O No {If ") e: [type of treat h: {Applicant will	/es"}[Ple ment, surg have the al	ease provio	de additi /sical the	onal details: erapy]		led or completed (besi	ides

Name:



Phone Number: [123-456-789	0]		
Address Line 1: [123 Health S	treet]		
Address Line 2:			
City: [City]			
State and Zip: [TX] [12345]			
Start Date: [MM/YYYY]			
Stop Date: [MM/YYYY]			
Fully Recovered? O Yes O No			
Additional Details: [details]			
40. American a filosofia a manifesta de 1.00 a	Laborat MDI EKO Esta	O.V. O.N.	
10. Any type of testing performed (i.e.	Lab Work, WIRI, EKG, Ecno,	O Yes O No)
Scan)?	data:la.		
{If "Yes"} Please provide additiona			Descrite and describe a testing of
Type of Test	Date of Test		Results and/or further testing?
[MRI]	[MM/YYYY]		[details]
[EKG]	[MM/YYYY]		[details]
[Lab work]	[MM/YYYY]		[details]]
11. Have you made a full recovery?	O Yes O No		
are yeu maae a ran recers, y	2 100 2 110		
Condition Detail			
URINARY TRACT DISORDERS (Only a	sked if Applicant chose Kidne	v Disorder: Urinarv E	Bladder Disorder: Kidnev Stones:
Prostate Disorders; or Other Urinary Tra			
	r] [Urinary Bladder Disorde		
	lers] [Other Urinary Tract Di		
-		· /-	
1. Do you have or have you had a hist			
O Renal Failure	Polycystic Kidney	Disease O Dia	lysis or Kidney Transplant
Recipient			
 Chronic Nephritis or Nephrotic Syndro 			vated PSA
O Other	Kidney Stones	O BP	H (Benign Prostate Hypertrophy)
{The following question is only applical	ole if the Applicant selects "Ot	her": "Kidnev Stones	": "Elevated PSA": or "BPH" from
(The renorming queeners to early applican	the list above		, Elevateur Gri, er Er inn nem
2. What is/was the diagnosis of your	[diagnosis]	·	
condition?	[diagnoolo]		
{The following question is o	only applicable if the Applicant	t selects "Kidney Stor	ne" from the list above.}
3. Please provide additional details fo	Kidney Stones:		
Number of occurrences: [number]	•		
Was (were) stone(s) passed?	O Yes O No		
Are stones now believed to be present?	O Yes O No		
Details: [details]			
	nly applicable if the Applicant	selects "Elevated PS	SA" from the list above.}
4. Please provide additional details fo	r Elevated PSA:		
Most Recent Results: [number]			
Date of Result: [MM/YYY]			
•	orod. [MM/\/\/\]		
5. Date condition diagnosed or discov	ered: [MM/YYYY]		
6. Is the condition still present?	O Yes O No		
Please supply date of last occurrence	: [MM/YYYY]		



7. Have you ever bee hospitalized?			O Yes O No						
{If "Yes"} [Please;		l details:							
	Disability / Hospitalization Start Date Stop Date								
[details]			[MM/DD/YYY		[MM/DD/YYYY]				
[details]			[MM/DD/YYY		[MM/DD/YYYY]				
[details]			[MM/DD/YYY	Y]	[MM/DD/YYYY]]				
8. Was medication tal			O Yes O No						
Medication	Dosage/Fred		Start Date	Stop Date	Dr. advised/aware of stopping				
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]				
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]				
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]				
9. Please indicate the physicians or facilities who treated you for the condition(s) (most current first). Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info} [Harris HEB] Name: Phone Number: [123-456-7890] Address Line 2: [City: [City] State and Zip: [TX] [12345] Date Seen: [MM/YYYY] 10. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? O Yes O No {If "Yes"} [Please provide additional details: Type: [Type of treatment, surgery or physical therapy] Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info} [Harris HEB] Name: Phone Number: [123-456-7890] Address Line 1: [123 Health Street] Address Line 2: [City] State and Zip: [City] State and Zip: [MM/YYYY] Stop Date: [MM/YYYY]									
Additional Detail									
11. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? {// "Yes"} [Please provide additional details:									
Type of T		ar dolallo.	Date of Tes	 st	Results and/or further testing?				
[MRI]			[MM/YYYY		[details]				
[EKG]			[MM/YYYY	•	[details]				
[Lab wor	kl		[MM/YYYY	•	[details]				
_	-		•		i [aciano] j				
12. Have you made a	tull recovery?	O Yes) No						

Condition Detail

DIGESTIVE TRACT DISORDERS (Only asked if Applicant chose Stomach Disorder; Intestines Disorder; Gallbladder Disorder;



		SIA	IEMENI OF	VARIABILITY			
Liver Disorder; Pancre INFORMATION [section:	on one] question [Stomach Diso	#9} rder] [Inte	stines Disorder]	[Gallbladder Dis	sorder] [
1. Do you have or haveO Hepatitis other thanO Bleeding or RecurreO Any Weight Loss StoryO Liver abscess or enO Other	Acute Type A ent Ulcer within 5 urgery	years		ancreatitis		O Peritontis within 1 y O Megacolon O Any Esophageal Varoids	
{The 2. What is/was the diacondition?		n is only ap	pplicable if the App [diagnosis]	olicant selects "Ot	ther" from	the list above.}	
3. Date condition diag	gnosed or disco	vered:	[MM/YYYY]				
4. Is the condition sti Please supply date		e:	O Yes O No [MM/YYYY]				
5. Have you ever bee hospitalized? {// "Yes"}[Please		l details:	O Yes O No				
Disability / Hosp			Start Date			Stop Date	
[details			[MM/DD/YYY			[MM/DD/YYYY]	
[details			[MM/DD/YYY	Υj		[MM/DD/YYYY]	
[details]			[MM/DD/YYYY] [MM/DD/YYYY]]				
6. Was medication ta {// "Yes"} [Please			O Yes O No				
Medication	Dosage/Fred	quency	Start Date	Stop Date	Dr.	advised/aware of sto	pping
[medication]	[15mg twice p		[MM/YY]	[MM/YY]		[details]	
[medication]	[15mg twice p		[MM/YY]	[MM/YY]		[details]	
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]		[details]]	
Physician or Facili Nam Phone Numbe Address Line Address Line Cit State and Zi	n: {Applicant will ty [Harris HEB] e: er: [123-456-789 1: [123 Health 9 2: y: [City]	have the ab 90] Street]				current first). Jously entered physician i	info}
8. Is there any type medication)? O Y Typ Treating Physicia Physician or Facili Nam	Yes ○ No {If "\ e: [type of treat n: {Applicant will ty [Harris HEB]	Yes"} [Pleament, surgenth have the ab	ase provide addition or physical the	onal details: erapy]		ended or completed ously entered physician i	

Phone Number: [123-456-7890] Address Line 1: [123 Health Street]



Address Line 2:

City: [City]

State and Zip: [TX] [12345] Start Date: [MM/YYYY] Stop Date: [MM/YYYY] Fully Recovered? • Yes • No Additional Details: [details]

9. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo,

O Yes O No

Scan)?

{If "Yes"} I Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details]]

10. Have you made a full recovery? • Yes • No

Condition Detail

COLON DISORDERS (Only asked if Applicant chose Hernia; Hemorrhoids; Polyps; or Rectal Disorders in ADDITIONAL

HEALTH INFORMATION [section one] question #10}

Condition: [Hernia] [Hemorrhoids] [Polyps] [Rectal Disorders]

Description: [description] Hospitalization required? O Yes O No Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate

physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

> Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [TX] ZIP [12345]

Code:

[Date: [MM/DD/YY]]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

EYE, EAR, NOSE, THROAT DISORDERS (Only asked if Applicant chose "Eye Disorder"; "Ear Disorder"; "Nose Disorder"; or "Throat Disorder" in ADDITIONAL HEALTH INFORMATION [section one] question #11}

Condition: [Eye Disorder] [Ear Disorder] [Nose Disorder] [Throat Disorder]

Description: [description] Hospitalization required? • Yes • No



Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATIONDOSAGE / FREQUENCYSTART DATESTOP DATE[medication][50mg; once per day][MM/YYYY][MM/YYYY][medication][100mg; once per day][MM/YYYY][MM/YYYY]

Condition Detail

SKIN DISORDERS {Only asked if Applicant chose "Burns"; "Lacerations"; "Dermatitis"; "Boils"; "Chronic Rashes"; "Melanoma"; or "Other Skin Disorder(s)" in ADDITIONAL HEALTH INFORMATION [section one] question #12}

Condition: [Burns] [Lacerations] [Dermatitis] [Boils] [Chronic Rashes] [Melanoma] [Other Skin

Disorder(s)]

Description: [description] **Hospitalization required?** O Yes O No

Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATIONDOSAGE / FREQUENCYSTART DATESTOP DATE[medication][50mg; once per day][MM/YYYY][MM/YYYY][medication][100mg; once per day][MM/YYYY][MM/YYYY]



		0.77	TEMENT OF	V/(I(I)(BIEII		
	Bursitis; or Ne	euritis in ADI	DITÍONAL HEAL	TH INFORMATIC	N [section one] qu	
 Do you have or have you had a history of: Rheumatoid Arthritis Systemic Lupus Scoliosis greater than 30 degrees or with Rods Muscular Distrophy AS (Ankylosing Spondylitis Other 			 Severe or Disabling Degenerative Joint Disease Severe or Disabling Disc Disease Neuropathy Severe or Disabling Osteoporosis Arthritis requiring gold treatments or Methotrexate Chronic Pain Syndrome 			
{The formula and the diagram of the condition?			oplicable if the Ap [diagnosis]	plicant selects "C	Other" from the list	above.}
3. What is the specific	area	Back:	O Up	per	Middle	O Lower
involved? Other Lo Details: [details]		Other Loca [details]	cation: O Right		O Left	O Other
4. Date condition diagr	osed or disc	overed:	[MM/YYYY]			
			O Yes O No [MM/YYYY]			
6. Have you ever been hospitalized? {/f "Yes"} [Please pro		al details:	O Yes O No			
Disability / Hospita			Start Date	<u> </u>		Stop Date
[details] [details] [details]			[MM/DD/YYYY] [MM/DD/YYYY] [MM/DD/YYYY]		1M] 1M]	M/DD/YYYY] M/DD/YYYY] I/DD/YYYY]
7. Was medication taken or prescribed? O Yes O No { If "Yes" Please provide additional details:						
Medication	Dosage/Fre		Start Date	Stop Date	Dr. advised	d/aware of stopping
[medication]	[15mg twice		[MM/YY]	[MM/YY]		[details]
[medication] [medication]	[15mg twice		[MM/YY] [MM/YY]	[MM/YY] [MM/YY]		[details] [details]]
[medication] [15mg twice per day] [MM/YY] [MM/YY] [details]] 8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first). Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info} Physician or Facility [Harris HEB] Name: Phone Number: [123-456-7890] Address Line 1: [123 Health Street] Address Line 2: City: [City] State and Zip: [TX] [12345] Date Seen: [MM/YYYY]						

[Date: [MM/DD/YY]]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? O Yes O No {If "Yes"} [Please provide additional details:



Type: [ty	pe of treatment	t, surgery or p	nysicai therapy	/]
-----------	-----------------	-----------------	-----------------	----

Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info}

Physician or Facility [Harris HEB]

Name:

Phone Number: [123-456-7890] Address Line 1: [123 Health Street]

Address Line 2:

City: [City]

State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? O Yes O No
Additional Details: [details]

10. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, O Yes O No

Scan)?

{If "Yes"} | Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details]]

11. Have you made a full recovery? • O Yes O No

Condition Detail

COMPLICATIONS OF PREGNANCY {Only asked if Applicant chose "Cesarean Section" or "Other Complications of Pregnancy" in ADDITIONAL HEALTH INFORMATION [section one] question #14}

Condition: [Cesarean Section] [Other Complications of Pregnancy]

Description: [description]

Hospitalization required? O Yes O No
Operation required? O Yes O No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100] City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

i rescription information			
MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]



BRAIN DISORDERS {Only asked if Applicant chose Epilepsy; Fainting Spells; Dizziness; Seizures; Paralysis; Tremors; Palsy; Head Injury; Chronic Headaches; or Other Brain Disorder(s) in ADDITIONAL HEALTH INFORMATION [section one] question #15}

Condition: [Brain Disorder] [Epilepsy] [Fainting Spells] [Dizziness] [Seizures] [Paralysis] [Tremors] [Palsy] [Head Injury] [Chronic Headaches]

1. Do you have or have you had a history of: O Brain Bleed (Cerebral Hemorrhage) O Narcolepsy O Cerebral Palsy O Stroke or Cerebrovascular Attack O Neuropathy O Brain Abscess within 5 years O Tourette's Syndrome O TIA (Transient Ischemic Attack) O Alzheimer's Disease O Congenital Brain Disorder O Pituitary Tumor O Hydrocephalus with Shunt/Stent O Malignant Brain Tumor O Parkinson Disease O Other {The following question is only applicable if the Applicant selects "Other" from the list above.} 2. What is/was the diagnosis of your [diagnosis] condition? 3. If seizure(s), type of seizure(s) [type of seizure] Frequency: [frequency] 4. Date condition diagnosed or discovered: [MM/YYYY] O Yes O No 5. Is the condition still present? Please supply date of last occurrence: [MM/YYYY] O Yes O No 6. Have you ever been disabled or hospitalized? Disability / Hospitalization **Start Date Stop Date** [details] [MM/DD/YYYY] [MM/DD/YYYY] [details] [MM/DD/YYYY] [MM/DD/YYYY] [details] [MM/DD/YYYY] [MM/DD/YYYY]] 7. Was medication taken or prescribed? O Yes O No {If "Yes"} [Please provide additional details: Medication Dosage/Frequency Start Date Dr. advised/aware of stopping Stop Date [medication] [15mg twice per day] [MM/YY] [details] [MM/YY] [15mg twice per day] [medication] [MM/YY] [MM/YY] [details] [medication] [15mg twice per day] [MM/YY] [MM/YY] [details] 1 8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first). Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info} Physician or Facility [Harris HEB]

Name:

Phone Number: [123-456-7890] Address Line 1: [123 Health Street]

Address Line 2:

City: [City]

State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? O Yes O No {If "Yes"} [Please provide additional details:

Type: [type of treatment, surgery or physical therapy]

Treating Physician: {Applicant will have the ability to select from a drop-down list based on previously entered physician info}

Physician or Facility [Harris HEB]



Name:

STATEMENT OF VARIABILITY

Phone Numb	er: [123-456-78	90]			
Address Line	1: [123 Health	Street]			
Address Line	2:				
Ci	ty: [City]				
State and Z	ip: [TX] [12345]				
Start Da	te: [MM/YYYY]				
	te: [MM/YYYY]				
	d? O Yes O N	0			
Additional Detail					
10. Any type of testii	ng performed (i.e	e. Lab wor	k, MRI, EKG, Ech	o, O Yes	O No
Scan)?					
{If "Yes"} [Please	e provide addition	al details:			
Type of 1	Test		Date of Tes	st	Results and/or further testing?
[MRI]			[MM/YYYY	7	[details]
[EKG]			[MM/YYYY	ī	[details]
[Lab wo			[MM/YYYY	•	[details]]
•	-	0 W 0	-	•	
11. Have you made a	a full recovery?	O Yes C	No		
Condition Detail					
	OUS DISORDER	S {Only as	ked if Applicant cl	hose Mental Disor	rders; Nervous Disorders; Depression;
					ction one] question #16}
					nxiety] [Alcoholism] [Drug Addiction]
Oomaniom	[montal Bloord	0.0] [.10.1		[Bobiocolon] [/t	indicty][/illocitonicini] [bildg/illocitoni
1. Do you have or ha	ve you had a his	story of:			
 Alzheimer's Diseas 			Cerebral Palsy		O Psychosis or Psychotic Disorders
Anorexia or Bulimia	a		Chemical Imbala	ance	O Nervous Breakdown within 5 years
O Moderate or Severe			Dysthymic Disor		O Neuropathy
O Autism	- - -		Manic or Major I		O Schizophrenia
O Bipolar Disorder			Post Traumatic		O Other
(The	following avection	an ia anbia	anliaahla if tha An	nlicont colonta "O	the oull fue we the list above ?
				piicant selects. O	ther" from the list above.}
2. What is/was the di	agnosis of your		[diagnosis]		
condition?					
3. Date condition dia	gnosed or disco	vered:	[MM/YYYY]		
4. Is the condition st	•		O Yes O No		
Please supply date	of last occurrenc	e:	[MM/YYYY]		
5. Have you ever bee	en disabled or		O Yes O No		
hospitalized?	on disabled of				
{If "Yes"} [Please	provide additiona	ıl details:			
Disability / Hosp			Start Date	1	Stop Date
[details			[MM/DD/YYY		[MM/DD/YYYY]
[details			[MM/DD/YYY		[MM/DD/YYYY]
[details	•		[MM/DD/YYY	•	[MM/DD/YYYY]]
lactana	1]	ן זי ישטייטיין	• 1	[14114112011111]
6. Was medication ta			O Yes O No		
{If "Yes"} [Please			_	_	
Medication	Dosage/Fred		Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice p	per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice p	per day]	[MM/YY]	[MM/YY]	[details]
(VAR STMT) CH/MG-			40		[Date: [MM/DD/YY]]
, , , , , , , , , , , , , , , , , , , ,	(,			[[



[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]		[details]]
7. Please indicate the ph Treating Physician: Physician or Facility					
Name: Phone Number: Address Line 1: Address Line 2: City:	[123 Health Street]				
State and Zip: Date Seen:					
medication)? O Yes Type: Treating Physician: Physician or Facility Name: Phone Number: Address Line 1: Address Line 2:	O No {If "Yes"} [Pleatitype of treatment, surget {Applicant will have the about [Harris HEB] [123-456-7890] [123 Health Street] [City] [TX] [12345] [MM/YYYY] [MM/YYYY] O Yes O No [details]	ase provide additi ery or physical the oility to select from a	onal details: erapy] a drop-down list base	d on previously	d or completed (besides
Scan)? { f "Yes"} Please pro	ovide additional details:				
Type of Test		Date of Tes	st	Results	and/or further testing?
[MRI] [EKG] [Lab work]		[MM/YYYY [MM/YYYY [MM/YYYY	Ī		[details] [details] [details]]
10. Have you made a fu	ull recovery? O Yes	O No			
ADDITIONAL HEALTH IN		ne] question #17}	_	se" or "Conned	ctive Tissue Disorder(s)" in
Hos	Description: spitalization required? Operation required?	[description] O Yes O No O Yes O No			
Treatment Information	Treatment: Start Date:	[details] [MM/DD/YYYY]		Stop Date:	[MM/DD/YYYY]
Enter the treatir physician details		ation below or s	select previously	entered phy	rsician name to populate



Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

ABNORMAL TEST RESULTS {Only asked if Applicant chose "Abnormal Results from PAP Smear"; "Abnormal Results from Mammogram"; "Abnormal Results from CEA..."; "Abnormal Results from PSA..."; "Abnormal Results from Other Test" in ADDITIONAL HEALTH INFORMATION [section one] question #18}

Condition: [Abnormal Results from PAP Smear] [Abnormal Results from Mammogram]

[Abnormal Results from CEA (Carcinoembryonic Antigen)] [Abnormal Results from PSA (Prostate Specific Antigen)]

[Abnormal Results from Chest X-Ray] [Abnormal Results from Other Test]

Description: [description]

Hospitalization required? O Yes O No

Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

i rocompulati illiananan			
MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

SYMPTOMS OF OTHER MEDICAL CONDITIONS {Only asked if Applicant chose "Abnormal Bleeding" or "Night Sweats" to ADDITIONAL HEALTH INFORMATION [section one] question #19}

Condition: [Abnormal Bleeding] [Night Sweats]

Description: [description]

Hospitalization required? O Yes O No



Operatio	n required?	O Yes O No					
Treatment Information							
	Treatment: Start Date:	[details] [MM/DD/YYYY]		Stop Date:	[MM/DD/YYYY]		
Enter the treating physic physician details.	Enter the treating physician's information below or select previously entered physician name to populate physician details.						
Physician or Fi Pho Adi Adi	ng Physician: acility Name: one Number: dress Line 1: dress Line 2: City: State:	[physician's name] [name] [123-456-7890] [123 Anywhere St.] [Suite 100] [My Town] [TX]	ZIP Code:				
Prescription Information MEDICATION D	OSAGE / FRE	FOLIENCY	START DATE	=	STOP DATE		
[medication]	[50mg; once		[MM/YYYY]	_	[MM/YYYY]		
[medication]	[100mg; once		[MM/YYYY]		[MM/YYYY]		
		· ·	-				
Condition Detail URINARY TRACT DISORDERS {O INFORMATION [section one] questi Condition: Swollen or I 1. Do you have or have you had a O Renal Failure	ion #19} Enlarged Pros history of:	•	, and the second		DDITIONAL HEALTH ney Transplant Recipient		
O Chronic Nephritis or Nephrotic Sy O Other	ndrome C	Chronic Glomerulon Kidney Stones	ephritis O E	levated PSA	Prostate Hypertrophy)		
{The following question is only app	olicable if the A	Applicant selects "Othe the list above.}	er"; "Kidney Sto	ones"; "Elevat	ed PSA"; or "BPH" from		
2. What is/was the diagnosis of yo condition?	our	[diagnosis]					
{The following question is only applicable if the Applicant selects "Kidney Stone" from the list above.} 3. Please provide additional details for Kidney Stones: Number of occurrences: [number] Was (were) stone(s) passed?							
{The following question is only applicable if the Applicant selects "Elevated PSA" from the list above.} 4. Please provide additional details for Elevated PSA: Most Recent Results: [number] Date of Result: [MM/YYY]							
5. Date condition diagnosed or dis	scovered:	[MM/YYYY]					
6. Is the condition still present? Please supply date of last occurre	ence:	O Yes O No [MM/YYYY]					



7. Have you ever been disabled or O Yes O No hospitalized?						
{If "Yes"} [Please p		l details:				
Disability / Hosp			Start Date		Stop Date	
[details]			[MM/DD/YYY		[MM/DD/YYYY]	
[details]			[MM/DD/YYY	•	[MM/DD/YYYY]	
[details]			[MM/DD/YYY	Y]	[MM/DD/YYYY]]	
8. Was medication taken or prescribed? • Yes • No {If "Yes"} [Please provide additional details:						
Medication	Dosage/Freq	uency	Start Date	Stop Date	Dr. advised/aware of stopping	
[medication]	[15mg twice p		[MM/YY]	[MM/YY]	[details]	
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]	
[medication]	[15mg twice p	er day]	[MM/YY]	[MM/YY]	[details]]	
medication)? O Y Type Treating Physicial Physician or Facili Name Phone Numbe Address Line Address Line Address Line Cit State and Zi Start Date Stop Date Fully Recovered Additional Details	n: {Applicant will ty [Harris HEB] e: e: [123-456-789] 1: [123 Health See: [123 Health See: [TX] [12345] 1: [MM/YYYY] e of treatment, Yes O No {If "Yes: [Type of treatment of the eight of	have the aid 90] Street] surgery /es"} [Ple ment, surg have the aid 90] Street]	or physical ther ase provide additingery or physical the billity to select from a	apy scheduled, onal details: erapy] ordrop-down list base	recommended or completed (besides	
Scan)? {// "Yes"} [Please provide additional details:						
Type of Test Date of Test Results and/or further testing?						
[MRI]			[MM/YYYY		[details]	
[EKG]			[MM/YYYY	•	[details]	
[Lab wor	kl		[MM/YYYY	•	[details]	
12. Have you made a		O Yes		1	[80.20.10]]	

Condition Detail

MUSCULAR DISORDERS (Only asked if Applicant chose "Neurological Disease/Disorder"; "Numbness of an Extremity";



"Muscular Disease/Disorder"; or "Loss of Use of a Limb" in ADDITIONAL HEALTH INFORMATION [section one] question #20}

Condition: [Neurological Disease/Disorder] [Numbness of an Extremity] [Muscular Disease/Disorder]

[Loss of Use of a Limb]

Description: [description]

Hospitalization required? O Yes O No

Operation required? O Yes O No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

i recemplion imerination			
MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

RECENT MEDICAL TREATMENT {Only asked if Applicant chose "Yes" to MEDICAL QUESTION #22: ("WITHIN THE LAST FIVE YEARS, have you...")}

Description: [description]

Hospitalization required? O Yes O No

Operation required? • Yes • No

Treatment Information

Treatment: [details]

Start Date: [MM/DD/YYYY] Stop Date: [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]

Physician or Facility Name: [name]

Phone Number: [123-456-7890] Address Line 1: [123 Anywhere St.]

Address Line 2: [Suite 100]

City: [My Town]

State: [TX] ZIP [12345]

Code:

Prescription Information

MEDICATIONDOSAGE / FREQUENCYSTART DATESTOP DATE[medication][50mg; once per day][MM/YYYY][MM/YYYY]



[medication] [100mg; once per day] [MM/YYYY] [MM/YYYY]

Condition Detail

FAMILY HISTORY {Only asked if Applicant chose "Yes" to MEDICAL QUESTION #23: ("Have either of your parents, brothers, or sisters been diagnosed...")}

Condition: Family Record of Proposed Insured

FAMILY MEMBER	IMPAIRMENT	AGE AT ONSET	AGE AT DEATH
[Father] [Mother] [Brother]	[impairment]	[age]	[age] [n/a]
[Sister]			

Condition Detail

TRANSPLANT {Only asked if Applicant chose "Yes" to MEDICAL QUESTION #24 & 25: ("Have you or any Applicant ever received (or been diagnosed..." or " Have you or any Applicant ever consulted with or been treated by...")}

Condition: Transplant

Please provide additional details.

[details]

Additional Prescription Medications

Are there any additional prescription medications that you or any applicant are currently taking, or have been prescribed which have not yet been filled? • O Yes • O No

Medication **Dosage & Frequency** Condition **Stop Date Applicant Start Date** [John Doe] [180 mg; twice per day] [environmental allergies] [Allegra] [12/2006] [N/A] [Jane Doe] [Astelin] [2 sprays; twice per day] [environmental allergies] [07/2006] [N/A] [Baby Doe] [Zyrtec] [1 tsp; once per day] [environmental allergies] [08/2006] [03/2007]



PAYMENT INFORMATION

[CREDIT/DEBIT CARD INITIAL PAYMENT]

1st Payment: [\$\$\$.00]

Credit Card Type: [O VISA O MasterCard]

Name of Cardholder as it appears on the card: [John Doe]
Relationship of Payor to Primary Applicant: [self]
[Reason for Payor Being Different than Applicant: [reason]]

Type of Card: [O Credit O Debit]

Account Type: [Personal]

Credit Card Number: [5525-XXXX-XXXX-XX54]

Expiration Date: [01/10]

Cardholder's Billing Address Line 1: [address]

Cardholder's Billing Address Line 2:

City: [city]
State: [TX]
Zip: [zip code]

Cardholder's Phone Number: [phone number]

[EFT INITIAL PAYMENT]

1st Payment: [\$\$\$.00]

Bank Routing Number: [xxxxx9485]
Bank Account Number: [xxxxx0089]
Confirm Bank Routing Number: [xxxxx9485]
Confirm Bank Account Number: [xxxxx0089]

Check Number: [1000]
Account Type: [Personal]

Name of Financial Institution: [My Favorite Bank]

Primary Name on Bank Account: Title: [Mr.] Name: [John C. Doe]

Relationship of Payor to Primary Applicant: [O Self O Spouse O Guardian O Approved Family Member] [Reason for Payor Being Different than Applicant: [reason]]

eason for Payor Being Different than Applicant: [reason]]
Same mailing address as Primary Applicant? • Yes • No

{If "No"} [Mailing Address: [address]
Apt or Suite Number: [number]

City: [My Town]

State: [TX] **ZIP Code:** [12345]]

[Date: [MM/DD/YY]]

Driver's License Number of Primary on Bank Account: [xxxxxx78] State: [TX]

NOTICE: PAYMENT AUTHORIZATION

Transaction Authorization: By typing in my driver's license or identification number above, I confirm that I am the owner of the account identified by the MICR numbers entered in the Internet check [above] and authorize this merchant and/or TeleCheck to convert my account information entered above into a paper draft drawn on, or an electronic debit to, my account for the amount of this transaction. [If you choose to use a different form of payment, please click Previous.]

For more information on TeleCheck's process and privacy policy, see {hyperlink} Internet Check FAQ and {hyperlink} TeleCheck Privacy Policy.



[ONGOING PAYMENTS]

Ongoing Payments: [● Checking Account Electronic Fund Transfer (EFT)

O Savings Account Electronic Fund Transfer (EFT)

O Bill Me]

Payment Mode: [Monthly O Quarterly O Annually]

Bank Routing Number: [xxxxx9485]
Bank Account Number: [xxxxx0089]
Confirm Bank Routing Number: [xxxxx9485]

Confirm Bank Account Number: [xxxxx9485]

Account Type: [Personal]

Name of Financial Institution: [My Favorite Bank]
Primary Name on Bank Account: [John C Doe]

Relationship of Payor to Primary Applicant: [relationship]
[Reason for Payor Being Different than Applicant: [reason]]

HEALTH APPLICATION TERMS AND CONDITIONS

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the certificate/policy is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

ELECTRONIC SIGNATURE – [John Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

ELECTRONIC SIGNATURE – [Jane Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Jane] MI: [A] Last Name: [Doel Suffix:

(VAR STMT) CH/MG-25098-eAPP (03/09) AR 48 [Date: [MM/DD/YY]]



FOR HOME OFFICE USE ONLY

[office use only text] {only agent allowed to fill in text here} Special Request(s):

[Association] Membership: [NASE Premiere] {system-generated} [Association] Membership Number: [0123456789] {system-generated} [Association Membership] Paid-to Date: [09/15/2008] {system-generated} [Association Membership] Effective Date: [06/15/2008] {system-generated}

Lead ID: [1234-ABC]

Market Type: [Association Group (I)]

ELECTRONIC SIGNATURE – [Bobby Gr	reatagent]			
Producer ID: [123456789]				
Do you have any knowledge or reason to		sed Insured(s) is in	itending to replace or o	therwise reduce in value
any existing life insurance or annuities?	J res J No			
By checking the box and entering my na electronically sign this application.	ame below, I am indicat	ting my agreemen	t with the indicated sta	tement and my intent to
☐ I certify that each question on thi answers given by the Applicant(s).	s application was aske	d by me of the A _l	pplicant(s), and I have	accurately recorded all
OR				
 I certify to the best of my knowledge on this application. 	ge and belief the Applica	ant(s) has/have pe	rsonally recorded the a	nswers to each question
Please type your name in the spaces bell First Name: [Bobby]	ow to electronically sign MI: [B]	your application. Last Name:	[Greatagent]	Suffix:
Please re-type your name in the spaces be First Name: [Bobby]	below to confirm your sig MI: [B]	gnature. Last Name:	[Greatagent]	Suffix:

END OF APPLICATION FOR INSURANCE